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Report of the
**Auditor General
of Canada**
to the House of Commons

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Chapter 4
Military Health Care—National Defence



Office of the Auditor General of Canada

The October 2007 Report of the Auditor General of Canada comprises Matters of Special Importance, Main Points—Chapters 1 to 7, Appendices, and seven chapters. The main table of contents for the Report is found at the end of this publication.

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Chapter

4

Military Health Care
National Defence

All of the audit work in this chapter was conducted in accordance with the standards for assurance engagements set by the Canadian Institute of Chartered Accountants. While the Office adopts these standards as the minimum requirement for our audits, we also draw upon the standards and practices of other disciplines.

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Military Health Care

National Defence

Main Points

What we examined

National Defence and the Canadian Forces provide medical and dental care to over 63,500 Canadian Forces personnel on 37 military installations across Canada and abroad, as well as to some Reservists and others who are entitled to medical care under certain circumstances. Care is provided mostly by health care practitioners who are members of the Regular Force, the Reserves, or the public service. About 540 civilian professionals such as physicians, nurses, physiotherapists, psychiatrists, psychologists, and social workers are contracted to provide health care at Canadian Forces medical clinics across the country. The Primary Care Renewal Initiative and the Mental Health Initiative are both key components of Rx 2000, a major health care reform begun by the Department in 2000.

We examined how National Defence determines that the Canadian Forces physical and mental health care system provides military members with timely, consistent access to quality health care in Canada. We also examined how the Canadian Forces health care system can ensure that its health care practitioners are qualified and can maintain their clinical skills and their licences to practice. We did not examine the Canadian Forces dental system.

Why it's important

Members of the Canadian Forces are excluded from the *Canada Health Act*; the provision of their health care falls under the *National Defence Act*. If a military member needs medical services, it is the responsibility of National Defence to ensure that the services are provided. Canadian Forces members serve in Canada and abroad in activities that could expose them to high risk, and therefore they must be assured of the necessary medical coverage. It is the Department's policy that members will receive health benefits and services comparable with those provided to other Canadians through provincial plans and under the *Canada Health Act*, tailored to meet operational requirements and members' unique needs.

National Defence spends over \$500 million annually to deliver health care benefits and services. Given the planned expansion of the military

and the current high tempo of operations, the demand for military health services can be expected to increase.

What we found

- In its Spectrum of Care policy, the Canadian Forces sets out its commitment to providing its members with access to the same health care services that other Canadians receive and to enabling continuity of care—two areas that National Defence previously identified as concerns. The Rx 2000 reform begun in 2000 has made significant efforts to adopt best practices for the delivery of health care. The reform has strengthened case management to help seriously ill or disabled members navigate through the Canadian Forces and civilian health care systems and obtain the services and benefits for which they are eligible.
- Canadian Forces members surveyed by military clinics said they were satisfied with the care they receive. However, the cost of military health care is rising. While the expenditure for health care for other Canadians in 2006 was estimated at about \$4,500, the expenditure per military member was estimated at more than \$8,600 (in the 2005–06 fiscal year). Although there are many factors that contribute to the cost of the military health care system, National Defence does not have measures or indicators to demonstrate whether the present accessibility of medical services and the resulting costs are operationally necessary.
- The Canadian Forces is unable to demonstrate that all of its military health care professionals are licensed or certified or have maintained their qualifications to practice. Furthermore, some Canadian Forces Health Services policies—used to ensure that health care providers comply with best practices—are outdated. Few military health practitioners take advantage of the Maintenance of Clinical Skills Program, although it is mandatory, because they believe they cannot be spared from their regular duties. The Department does not evaluate the program, so it does not know how many have gone through it and qualified, at what level, and whether they actually learned to treat the kinds of injuries for which the program was intended.
- National Defence and the Canadian Forces have little information to demonstrate how well the Canadian Forces health system is performing or to assess the quality of care provided to Regular Force members. National Defence does not measure to what extent the health care system is achieving expected outcomes; nor has it defined what outcomes it expects. Development of the new Canadian Forces Health Information System, intended to provide

relevant and reliable information on patient care, began in 1999 and is expected to be finished in 2011. It currently has limited capability for the management of health information.

- National Defence recently began providing a broad range of mental health care services based on best practices. However, demand for mental health care is outstripping available resources. The Department has been referring some patients to practitioners in the private sector but has difficulty monitoring their care.

National Defence has responded. National Defence has agreed with our recommendations and is taking action to address the concerns raised in the chapter. Its detailed response follows each recommendation throughout the chapter.

Introduction

4.1 National Defence is required to provide for the health care needs of Canadian Forces members under the *National Defence Act*, which gives the minister authority to manage and direct military health care matters. The *Canada Health Act* excludes Canadian Forces members from being covered under provincial health care plans.

Unlimited liability—Canadian Forces members are at all times liable to perform any lawful duty, including being lawfully ordered into harm's way under conditions that could lead to the loss of their lives.

Source: Department of National Defence

4.2 Military members serve with **unlimited liability** and, according to National Defence, should be given the same health benefits and services comparable to those provided to other Canadians through their provincial health care plans, but tailored to meet operational requirements and members' unique needs.

Background

4.3 National Defence provides medical care to more than 63,500 Regular Force personnel on 37 military installations across Canada and abroad, as well as to some Reservists and others who are entitled to medical care under certain circumstances. About 78 percent of Regular Force members seek medical attention each year. National Defence spends more than \$500 million annually to provide medical and dental care to its military members. This includes a full range of practitioners and services that are provided through National Defence clinics on bases or through the civilian health care systems and paid for by the Department. There are approximately 3,000 health care providers in the Department, consisting of Regular Force, Reserve Force, and public service personnel as well as civilians on contract. The Department has a contract with a private sector firm that provides more than 540 health care professionals full and part time to military clinics across the country (Exhibit 4.1).

4.4 Several National Defence reviews conducted between 1997 and 1999 concluded that military health services had significant deficiencies related to the delivery of health care. Deficiencies included

Continuity of care—Canadian Forces members receive continuity of care when they perceive that their health care provider knows what has happened to them before, that the various health care providers currently involved in their health care agree on a management plan, and that a provider who knows about them will care for them in the future.

Source: Department of National Defence

- lack of **continuity of care**;
- substantial regional differences in the provision of health care at installations across Canada;
- lack of strategic direction on how to provide care and low morale among health care professionals;
- too many clinicians performing strictly administrative functions;

- lack of ongoing quality improvement programs including the lack of oversight mechanisms to ensure compliance with clinical guidelines, established standards, and best practices;
- deficiencies in the management of health records;
- lack of accountability among providers; and
- concern about the access to and timeliness of health care.

Rx 2000—A National Defence initiative launched in 2000 to ensure a high standard of health care for the Canadian Forces members—anywhere, anytime. It is a proactive, multi-faceted reform that aims at making the Canadian Forces health care system patient-focused, accessible, and capable of meeting the needs of the member and operational chains-of-command at home and abroad while respecting the principles of the *Canada Health Act*.

Source: Department of National Defence

4.5 These findings led the Department to reform how it delivered health care by launching its **Rx 2000** reform in 2000. This aims to adopt best practices to ensure a high standard of patient-focused, accessible health care. The reform has 22 initiatives that are planned for completion by 2011 and an overall budget of \$450 million.

4.6 Between 2000 and 2004, as part of Rx 2000, the Department developed and tested the Primary Care Renewal Initiative, a new model to improve the delivery and continuity of care provided in its medical clinics. Under this model, all Canadian Forces medical clinics are to be accredited and offer a number of complementary health services, such as physiotherapy, pharmacy, laboratory, X-ray, case management, community health, preventive medicine, and mental and psychosocial services.

Exhibit 4.1 Health Services providers working for the Canadian Forces in 2006–07

Regular Forces Health Services providers	
Physicians and medical specialists (orthopaedic surgeons, anaesthetists, psychiatrists)	223
Nurses	226
Pharmacists	29
Physical therapists	30
Social workers	32
Medical technicians and physician assistants	1,345
Laboratory technicians	23
Radiology technicians	19
Dental officers, dental specialist officers	145
Dental technicians	203
Total Regular Force health services providers	2,275
Total Reserves Force health services providers	19
Total public servant health services providers	190
Total third-party contracted health services providers	543
Total	3,027

Source: Department of National Defence

4.7 The Department has contracted with a third party to provide health care professional services where shortages exist in the National Defence system. Through this third party about 540 full and part-time health care providers, such as physicians, nurses, psychologists, and physician assistants, are working at Canadian Forces medical clinics to deliver direct patient care. In the 2006–07 fiscal year, National Defence paid approximately \$60 million to obtain these services.

4.8 In cases where military members need access to medical facilities outside the normal weekly operating hours of the base clinics and on weekends, they may access provincial health care services. The Department has provided each member with private health care coverage through Blue Cross to use civilian health services. In the 2006–07 fiscal year, National Defence paid approximately \$66 million for this coverage and the medical services provided (excluding the cost of prescription drugs and dental services).

Focus of the audit

4.9 The objectives of this audit were to examine whether National Defence has the necessary structures, policies, and practices in place to provide assurance on the quality of health care that members of the Regular Force receive. We also examined the extent to which National Defence ensures that its health care providers are qualified and maintain their clinical skills.

4.10 The scope of the audit is limited to physical and mental health services provided to Regular Force members in Canada. We did not examine the dental services or review medical files to test for the appropriateness of medical treatment decisions. More details on the audit objectives, scope, approach, and criteria are in **About the Audit** at the end of this chapter.

Observations and Recommendations

Accessibility and continuity of health care

Previous concerns about accessibility and continuity of care are being addressed

4.11 According to National Defence, primary health care is defined as the care a patient receives at their first point of entry into the health care system, usually in a clinic. Previous departmental studies found several concerns with the primary care offered at base clinics, and concluded that members were not getting consistent access to care across the country or continuity in the care they were given.

4.12 To establish a consistent model for the provision of care across all medical clinics, the Department began in 2000 its Primary Care Renewal Initiative, as part of Rx 2000, to ensure members have timely and consistent access to quality primary care services they need, or could be referred to appropriate care providers as necessary. The Department set up an independent panel of primary health care experts to review its proposed clinic model and to comment on whether the model met generally accepted best practices for primary health care services. In October 2003, the panel found that the Department's new model was consistent with many of the characteristics of primary health care practices in Canada and better on two of the characteristics: access to a comprehensive range of health services and the provision of continued care from the same provider. The Department began implementing the new clinic model in 2004 and is expected to complete it by 2011.



Clinics are open for military personnel, who can walk in for medical care.

Source: Department of National Defence

4.13 During our audit, we found that the Canadian Forces health care system is committed to providing members with access to a full range of health care services either within the Canadian Forces health system or through civilian health care providers. National Defence allows its military members to use hospitals and health services that are not available within the Canadian Forces system. For example, because oncology is not a military medical specialty or part of the primary care services, any member who requires such treatment would be referred to an oncologist by the member's Canadian Forces physician and become a patient in the civilian health care system at departmental expense.

4.14 We also found that military members who walk in to their military clinic do not have to wait very long to access primary medical care. Departmental data shows that up to 85 percent of patients at clinics completed their medical visits within one or two hours, usually for non-urgent services. The most frequent reason for seeking medical attention was for musculoskeletal injuries: sprains, strains, and fractures (Exhibit 4.2).

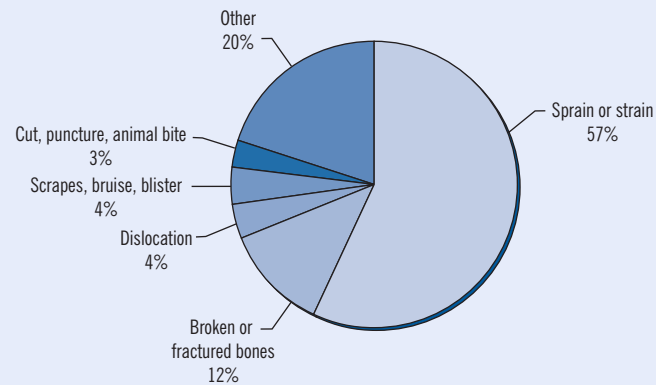
4.15 The clinics are also responsible for ensuring that military members who need more specialized care have access to specialists. In clinics we visited, we found that some have specialists come to the clinic once or twice a month to see patients. This has reduced waiting times to see specialists in some cases.

4.16 Continuity of care is partly achieved through the Canadian Forces' system of care delivery units in base clinics. A unit provides primary care with a multidisciplinary team of 10 health care providers:

Exhibit 4.2 Military physical health profile

In 2000 and 2004, National Defence surveyed its members about their health status and satisfaction with health care. In 2004, 94 percent of military members reported having excellent or very good health status.

Among those reporting injuries in the previous year, the most likely were from sprains or strains.



Twenty-eight percent of members reported sustaining repetitive strain injuries that were serious enough to limit their normal activities. This occurred most often during sports, physical activity, or at work. Twenty-six percent of members had an injury serious enough to limit their normal activities during the year preceding the survey. Acute injuries are more common in members aged 20–34 and among members of the Army.

Source: Department of National Defence

general duty physicians, nurse practitioners, physician assistants, and medical technicians. Each clinic can house one or more care delivery unit, depending upon the size of the population served, as well as provide mental health, psychosocial, and pharmaceutical services. Care delivery units focus on a set number of patients who go only to their assigned care unit. This enables continuity by directing members to the same group of practitioners who are familiar with their health status and who have access to their medical records. A National Defence survey conducted in 2004 showed that nearly two thirds of members considered continuity of care, in terms of seeing the same practitioner, to be very important, and that most reported they saw the same practitioner sometimes or always.

Most military members are satisfied with their health care services

4.17 According to a patient satisfaction review conducted by National Defence in 2006, more than 85 percent of those who responded reported they were satisfied with the health care they received. In 2004, a Canadian Forces Health and Lifestyle survey found that 83 percent of members felt their health concerns were

addressed at the time of their appointment, and 76 percent stated that they received results of tests and procedures within an appropriate time frame. More than 80 percent of members felt that the clinic hours met their needs.

Mental health care services have been reformed to better target needs

4.18 In 2002, at the request of National Defence, Statistics Canada conducted a survey on mental illness in the Canadian Forces and found that only 25 percent of respondents who had reported symptoms of mental health problems or disorders considered that they received sufficient help. In response to this and other reports, National Defence began restructuring how it delivered mental health care and developed an interdisciplinary model that involves collaboration among a variety of professionals, which can include psychiatrists, psychologists, social workers, mental health nurses, addictions counsellors, and pastoral counsellors. In all levels of mental health and addictions, the client's physician is involved as part of the interdisciplinary care model.

4.19 The new mental health care model divides services into psychosocial (primary care) and general (secondary care) mental health. Psychosocial services include social work and addictions counselling. General mental health services include care for illnesses such as depression. In addition, there are five regional centres for the treatment of operational stress injuries, which include mental illnesses resulting from military work. This model was approved in April 2004.

4.20 We found that National Defence is implementing the model nationwide and is following up with a validation of that model. It is employing a best practice in the mental health field; that is, an evidence-based practice whereby its qualified professionals in social work, addictions counselling, and the treatment of mental illnesses take part in training and have access to information on developments in treating mental health illnesses, in order to be up-to-date in their professions. New cases in mental health are discussed as part of interdisciplinary case reviews and are revisited to ensure follow-up.

4.21 The Department also began conducting enhanced post-deployment screenings of military personnel returning from overseas service to detect any resulting physical and psychological effects. Using a questionnaire and interviews, National Defence strives to detect and treat problems early, and to follow the impacts of deployments on its personnel.

Case managers are there to help patients navigate a complex process

4.22 In 2001, as part of Rx 2000, the Department created a network of case managers to be assigned to members on long-term sick leave or who would be leaving the military for medical reasons. The case managers would help them better understand the health care process and help them return to work, or ease the transition out of the military. Case managers navigate what can be a complex process and, if members are undergoing a medical release, they work to transfer health care services from National Defence to either Veterans Affairs Canada or the civilian system.

Monitoring health care delivery

Performance information from which to measure or monitor health care is very limited

4.23 The Canadian Forces health care system is structured around the expectation that military members will be fit and available for duty. The intent is to be aware of and treat any health conditions a member may have so that he or she can either return to work as soon as possible, or be released from the military.

4.24 In order to provide health care services to the Regular Force, the Department must know whether members are getting the care they need when they need it, appropriate to operational requirements. Therefore, we expected to see a performance measurement system in place that would provide reliable information on the performance of the health care system and the health of the military population overall. As well, because the Department has made considerable investments to reform its health care system since 2000, it needs indicators to measure whether it is achieving intended results.

4.25 National Defence has not yet developed a performance measurement system that would measure clearly what the health care system is achieving, at what cost, or what needs to be improved in the provision of health care. Although some information is available at clinics, the Department could not provide us with information on results and outcomes for the medical system overall. For example, we wanted to know if the Department had achieved acceptable waiting times at clinics but performance standards on acceptable wait times had not been established.

4.26 Getting consistent Canadian Forces-wide data on health care has been an ongoing challenge for senior management and has resulted in an ad hoc, reactionary approach to gathering management information. The Canadian Forces health system still relies on paper

medical records. As a result, unless the Department undertakes a considerable effort to gather data file by file, it is very difficult to provide any overall health information to management for analysis or monitoring. For example, we asked how many Canadian Forces members returning from Afghanistan were injured and what medical assessment they received. This information was not readily available and was only partially captured because of a health care provider who took the time to compile the data for his region. We also asked how many members were receiving care from a mental health professional, but the Department was unable to compile this data.

4.27 In July 2006, the Department began work on a Results-Based Management and Accountability Framework, as required by the Treasury Board of Canada Secretariat for all federal departments, and adapted it for the Primary Care Renewal Initiative. The framework had provided some performance indicators, but results have not yet been measured. Even though some health care data is collected at various sources—for example, lifestyle surveys, a sick leave database, and a mortality database—a performance measurement framework is still needed to measure how well the health care system is achieving desired results.

The new Canadian Forces Health Information System is still under development

4.28 Gathering reliable and timely performance information will require an information system that can collect the data. In 1999, the Department recognized that it had fallen behind the civilian health services sector in the provision of accurate and timely health information for care providers, patients, and decision makers at all levels. National Defence does not have a national database to capture and analyze health indicators, costs, or trends. To address this need, in 2000 the Department approved the development of a Canadian Forces Health Information System, a computerized system to manage patient files and generate health indicator information. The system is scheduled to be completed by the end of 2011.

4.29 At the time of our audit, the Department reported that \$53 million of the planned \$108-million expenditure had been spent on developing the system. Currently, it is providing only limited capability, such as scheduling of appointments, although some clinics can input patient laboratory and radiology results. Initially, the Department had planned to follow the Canadian Institute for Health Information guideline on medical information management in the design of its new health information system (the CIHI Standards for Management Information Systems in Canadian Health Service Organizations). However, in April 2006, this was excluded from the project due to a lack of funding.

Also, the overall ability to collect and analyze military health management information, such as information on the prevalence of specific sicknesses or injuries, is planned for completion at a later development phase. We are concerned that this will slow progress toward providing senior management with information to measure and monitor health care or to support decisions on priorities and the use of resources.

4.30 Recommendation. National Defence should identify those health care indicators to be used to measure whether it is providing quality care to Canadian Forces members.

Department's response. Agree. The Canadian Institute for Health Information and Statistics Canada have worked with numerous stakeholders in recent years in an attempt to gain national level consensus on both primary health care and population health indicators. The primary health care list published in 2006 includes 105 indicators and requires numerous survey and data collection tools for calculation. Over the next year, the Canadian Forces Health Services will select an initial core set of indicators that can be compiled from current data sources. These will be in keeping with pan-Canadian health indicators. In addition, the Canadian Forces Health Services will consult with key stakeholders to determine which of the many potential indicators should be used to report on the health of Canadian Forces members and the performance of the Canadian Forces health care system.

4.31 Recommendation. National Defence should develop a system that will provide it with the necessary information it needs to measure its performance against the indicators it establishes.

Department's response. Agree. The Department currently collects data from myriad sources including the Health and Lifestyle Information Survey, recruit questionnaires, patient satisfaction surveys, the mortality database, health data for deployed operations using the EPINATO database, the Canadian Forces sick leave database, survey reports from the Canadian Council on Health Services Accreditation, and internal reports based on visits to clinics and units by headquarters staff. However, the synthesis of this information into a unified picture of performance against predefined indicators is lacking. Maturation of the Canadian Forces Health Information System will help immensely in this regard.

The Department will also reconsider inclusion of the Canadian Management Information System standards within the Canadian Forces Health Information System project or funding of this tool as a separate initiative. Using the Management Information System

standards, which were developed by the Canadian Institute for Health Information, will provide a framework for the collection and reporting of day-to-day financial and statistical data. In addition, over the next two years, the Department will institute a performance measurement and decision support capability to build the capacity to collate data and assess performance against indicators.

Resource levels are not supported by efficiency or effectiveness measures

4.32 According to the Primary Care Renewal Initiative, each clinic is to house one care delivery unit for every 1,500 members on the base. However, the Department could not provide us with a workload analysis to support how its present level of access to clinical services was established, whether it was based on operational or medical needs, or how many of the 1,500 members assigned to each unit are reasonably expected to be patients.

4.33 We asked the Department how service levels were established and whether there were reviews done to determine if costs were appropriate. We were informed that

- quick patient turnaround—and the costs associated with delivering this level of service—had become the long-standing expectation in the Department; and that
- service delivery was based more on past practice than on an analysis of current needs or reasonable wait times that takes into account costs and efficiency.

4.34 We noted that some base mental health services could not meet demands due to a lack of staff, while others could offer all the services requested. We found that some bases reported a shortage of mental health professionals to meet needs and relied on services from civilian private practitioners, if and when available (Exhibit 4.3).

Exhibit 4.3 Helping military families cope with mental health disorders

According to the National Defence mental health model, “there is a moral obligation on the part of the Government of Canada to provide treatment and support to family members for conditions resulting directly from military service.” Although there is no legal obligation to treat families, mental health teams across the country try to help families when it is in support of a member’s health. The Department recognizes that treating mental health illnesses appropriately should also address the member’s environment, which for many members means helping the family cope as well. Thus, in order to meet obligations to treat the member, the Department may also need to include the family.

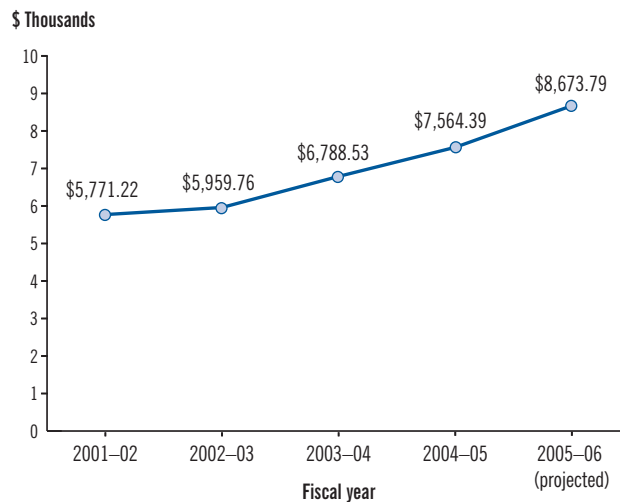
However, when surveyed by the Department, mental health services in places such as CFB Petawawa and CFB Galetown—bases with large numbers of members returning from deployment in Afghanistan—said they were unable to extend member care to include family support because of resource shortages.

Source: Department of National Defence

The cost of military health care delivery is increasing

4.35 In the 2005–06 fiscal year, the Canadian Forces health system spent an average estimate of more than \$8,600 per person, compared with the Canadian average estimated health care expenditure of about \$4,500 per person in 2006. This is despite the fact that departmental data shows that the military population tends to be relatively healthy: more than 90 percent of Regular Force members reported in 2004 that they were in good health. Exhibit 4.4 shows that the cost of delivering military health care has increased by 50 percent per person over the last five years.

Exhibit 4.4 Military health cost per person



Source: Department of National Defence

4.36 We found that there are many factors that contribute to the cost of the military health system to maintain this healthy population, such as the number of patients per physician and the fees paid to retain medical professionals on contract.

- **Number of physicians.** Overall, we found that there were four times more physicians per 1,000 military members compared with the civilian systems. We also found that almost 40 percent of military physicians are not providing patient care but are, instead, employed in administrative or other functions.
- **Physician workload.** We found that there is a broad range in workload at clinics across the country. Physicians at some clinics can be called upon to see, on average, more than 100 patients per week, whereas others see, on average, fewer than 40 per week.

The Primary Care Renewal Initiative calls for 1 physician per 500 people, or 3 physicians per care delivery unit, but the Department could not demonstrate what workload it expected at clinics when it established this ratio.

- **Costs to train military medical staff.** National Defence pays for the medical education and ongoing military training of some of its physicians, nurses, and other medical practitioners, including medical technicians and physician assistants. Physician assistant training has not generally been available through civilian educational systems.
- **Cost of physicians on contract.** To meet the resource levels established for the clinics, civilian health care practitioners have been hired on contract to fill in where staff shortages exist in the Department. National Defence uses two routes to hire these medical practitioners: through a third party and through direct contracts with individual physicians. We found several examples where National Defence was paying costs in excess of provincial averages to hire civilian physicians. Exhibit 4.5 compares the costs to hire physicians among categories of those working in the Department and with those working in the provincial systems.

Exhibit 4.5 Comparison of annual costs to hire physicians

Cost to National Defence (2006–07)	Annual cost per physician	
	From	To
Regular Force* (military physician)	\$ 207,464	\$ 231,082
Third-party contractor	\$ 176,937	\$ 336,538
Public service* (civilian physician)	\$ 124,159	\$ 165,846
Cost to provincial systems (2004–05)		
Physician average fee for service (not including alternate sources)	\$ 164,568	\$ 238,775

*Grossed up by 30% to take into account benefits

Source: Department of National Defence, Canadian Institute for Health Information, and Treasury Board Secretariat

Weak financial controls increase the risk of improper payments

4.37 During the audit, we found that several payments for physician services were difficult to verify. We noted examples where physicians on contract were paid for more than the hours they were to have worked, but there was no information available to determine whether

the payments were correct or made in error. In our sample, we found cases where it appeared that physicians were paid to work at a clinic when it was closed, or when they were absent. There were examples where it appeared that a few physicians had double-billed for hours worked. In those cases where a physician had two contracts to work for the Department—one through the third-party provider and one directly with the Department—we could not verify that payments made under each contract were not, in fact, for the same hours. We are concerned that clinic managers are approving payments under **Section 34 of the *Financial Administration Act*** without sufficient assurance that the charges are correct.

Section 34 of the *Financial Administration Act*—Under section 34, by signing an invoice, the signing authority is certifying that the invoice should be paid because the work has been performed, the services rendered, and the price charged is according to the contract.

Source: *Financial Administration Act* 34(1)

4.38 We found that irregularities occurred because clinic managers did not have all the information they needed to ensure that charges to the Department matched the services provided before signing for payment. Managers did not have a reliable record that showed them which contract physicians had worked at the clinics or when. Many managers did not have copies of the contracts in order to verify that the contract provisions were met; for example, to ensure that hours charged did not exceed the agreement. In the one clinic we observed that did keep reliable records, all payments we examined could be verified.

4.39 Recommendation. The Department should ensure that the levels of service provided at clinics and the associated costs are clearly linked to patient requirements and operational needs.

Department's response. Agree. In order to ensure that the levels of service provided at clinics are linked to patient requirements and operational needs, the Canadian Forces Health Services will introduce service delivery standards and utilize various tools to measure the effectiveness of the health services system. Civilian service delivery standards will be used as appropriate; however, they may need to be modified to take into account operational requirements. Other standards, unique to the needs of military personnel or that reflect the operational context of a military health care system, will also be developed.

Much work has already been done through the Rx 2000 Project to determine resource requirements and implement effective service delivery structures. Implementation and validation of the Primary Care and Mental Health models is ongoing, and the Canadian Forces Health Services workload management system is being modified to provide a more accurate reflection of clinical and operational workload. Using data already available from the Canadian Forces

Health Information System and other tools, it will be possible to objectively measure indicators of service delivery.

The Department has also taken action to tighten financial controls and manage risk. In the fall of 2006, all civilian and military managers in the Department were required to complete an online knowledge assessment in the areas of financial management, human resources, procurement, and information management. This directive was applied to healthcare clinic managers and the Department will ensure that all new clinic managers will undertake this knowledge assessment.

Quality of health care provided

National Defence needs better assurance on the quality of its health care

4.40 We examined the measures in place to ensure that Regular Force members receive quality medical care appropriate to their needs. We expected that the National Defence health care system would demonstrate evidence of some or all of the practices used by other Canadian health systems to indicate that quality care is provided, but we found that National Defence could not provide all the necessary assurances, including

- up-to-date standards of care that practitioners are expected to follow when providing care,
- clear responsibility for quality assurance and medical record review,
- licensing and/or certification of all medical practitioners who provide patient care,
- training and maintenance of professional skills, and
- independent accreditation of health care facilities.

4.41 Standards of Care. The Surgeon General of the Canadian Forces, as the senior medical authority, has put in place a professional technical network to oversee the provision of quality care to military members. The professional technical network identifies the base surgeon as the senior authority in each clinic who is responsible for overseeing the application of health policies and ensures that standards of care are adhered to. National Defence has recognized that, with the exception of mental health standards of care, about 35 percent of its standards of care policies for medical practice were outdated. Therefore, base surgeons must determine what care is appropriate to the best of their knowledge. Base surgeons are professionals who the Department has determined are medically qualified to provide this oversight. Nevertheless, a lack of current

and formally accepted practices across the military health system that care providers must follow means there is no assurance to senior management that consistent standards of care are provided to all military members.

4.42 Quality assurance and medical record review. One best practice is to establish a quality assurance program where there is a review of medical records to determine whether appropriate examinations were done, necessary diagnostic tests ordered, appropriate course of action identified, and patients monitored, as necessary. We did observe that some clinics are using a best practice multidisciplinary case review where base surgeons and clinic health care providers meet to determine how best to treat some cases. However, the Department has not yet put in place a formal quality assurance program where a committee of peers could periodically review medical records and determine whether military and civilian health care providers are adhering to clinical best practices.

4.43 We found that in some cases, the mental health care services available are insufficient to meet demands. Therefore, National Defence relies on civilian practitioners in the private sector to accept military patients when it cannot provide service appropriate to needs. However, while the mental health services can track patients internally, the Department could not provide us with evidence that cases where patients had been placed in civilian health care were subject to regular interdisciplinary case review, as called for in the Mental Health Initiative of Rx 2000. In some cases, patient progress was not monitored.

National Defence cannot assure that its military medical practitioners are all licensed, certified, or trained

4.44 Licensure or registration with a body that oversees a regulated health profession, such as the College of Physicians and Surgeons in each province, is the accepted indicator of competence and authority to practise a profession. Regulating professions ensures that patients are protected through established standards, ongoing monitoring of professional practices, and conduct and disciplinary processes. Under the *Controlled Drugs and Substances Act* (1996), all practising physicians, pharmacists, and dentists in Canada must be licensed.

4.45 The Surgeon General and the Department recognize that their health care providers should be licensed, in the case of a regulated profession, and/or certified by a professional association, in the case of a non-regulated profession. All regulated professionals, both military

and civilian, are licensed or certified before they are hired by the Department. However, the Department does not monitor its military health care practitioners once employed to ensure they maintain their licences or certification and are in good standing with a regulatory body. Canadian Forces Health Services officials reported to us that due to this lack of information, they do not know if unlicensed practitioners are currently providing direct patient care. The Department estimated in 2006 that as many as 20 percent of its military health care providers in a regulated profession may not have been licensed. Senior officials informed us that the Department is working on documenting the status of its health care providers.

4.46 Under Treasury Board policy, fees for licensing will be reimbursed for physicians, dentists, and pharmacists where licensing is a condition of employment. The Treasury Board Membership Fees Policy also says that the Deputy Minister's personal approval allows the reimbursement for all other health care provider membership fees on a case by case basis. However, the Department has not enforced a requirement to maintain a licence or certification of other medical providers, such as nurses or laboratory technicians. In January 2007, the Department's Deputy Minister approved payment of all health care providers' membership fees for one year for those who requested it. It is unclear whether the Department will continue this practice. Senior officials informed us that the Department is developing a policy on mandatory maintenance of a provincial licence.

4.47 Because the Department lacked the information, we conducted a survey and found that 69 percent of military physicians who responded provided us with evidence that they held a licence with a provincial regulatory body. When we inquired at the provincial colleges, we found that all these physicians were licensed. We did find that about 35 percent of the physicians were not licensed in the province in which they practised but, because military physicians transfer across Canada, they only need hold a licence from any province to practise in a military clinic. However, this prevented them from taking advantage of opportunities set up by the Department to work in civilian facilities to gain experience necessary for maintaining the full scope of their clinical skills.

4.48 We found that 75 percent of military nurses who responded to our survey provided us with evidence that they are licensed; however, most of the nurses working in a specialized field have not completed the voluntary national level certification in that specialty, such as emergency room nursing, operating room nursing, or critical care. Eighty-seven percent were licensed in the province in which they

worked, but only 47 percent worked in jobs that involved direct patient care.



Physician assistants and medical technicians are a key part of delivering military health care.

Source: Department of National Defence

4.49 Medical technicians and physician assistants make up about 50 percent of the current military medical workforce. They are a major component of health care delivery and are employed in clinics, with the troops and on ships. Medical technicians are a first line of medical care and can be compared to civilian paramedics. Physician assistants start out as medical technicians but, after years of experience and more advanced training, they become skilled caregivers who can also prescribe some drugs. Physician assistants are often the only medical care professionals aboard ship.

4.50 In 2001, the Department determined that the training for medical technicians was falling behind civilian standards. To address these concerns it started to provide civilian equivalent training for its medical technicians in 2002. It was intended that medical technicians would take a certification exam following the new training. This credential would allow medical technicians to work in civilian facilities for the maintenance and advancement of their clinical skills.

4.51 Of the 1,221 medical technicians, we found that the majority have been trained to the new standards but few are certified, often because they choose not to take the exam. We found that not all medical technicians pursued certification following their training because it was not mandatory.

4.52 In 2002, the Department also revised the physician assistant training that would require physician assistants to become certified as well. Fewer than half of the 124 physician assistants have been trained to the new standards and fewer than 20 percent have been certified, even though there is a departmental requirement to write the certification exam within 12 months of graduating from the new course. We found that some physician assistants have not pursued mandatory certification, but are in positions where they are expected to provide direct patient care.

4.53 As a result, a large portion of physician assistants in the military medical system are providing patient care without having been certified or, in some cases, without having passed the new standards. We found the following:

- Eight of 10 physician assistants who tried but did not pass the certification exam were providing direct patient care.
- Of the only 24 physician assistants who are certified, 6 of them were not used in patient care.

- Nine of 10 physician assistants hired through the third-party contractor to provide direct care were not certified. National Defence was informed of this. According to the terms of the contract, physician assistants must have completed the certification process.

Few military medical professionals are meeting requirements to maintain clinical skills

4.54 We found that National Defence expects all its military health care professionals to be able to perform the full scope of practice for their occupation and to be prepared to deliver a high standard of health care. However, many health care providers who are only employed in military clinics do not get exposure to a full scope of practice. The most frequent injuries that present at clinics are sprains, strains, and fractured bones. Therefore, military health care providers may not get the opportunity to perform a full spectrum of practice or be exposed to the emergency and trauma conditions they may face on deployed operations.

4.55 In 2005, the Department implemented its Maintenance of Clinical Skills Program for all military health care occupations. This program is a formal, mandatory process through which military health care providers must maintain knowledge and skills by completing a minimum number of training activities in a given amount of time. One of the mandatory activities is clinical placement in a civilian health care facility, usually a hospital, which requires health care providers to be licensed and/or registered.

4.56 The Department does not monitor and evaluate the Maintenance of Clinical Skills Program, so it does not know how many have gone through it and qualified, at what level, and whether they actually learned to treat the kinds of injuries for which the program was intended. We surveyed military physicians, nurses, medical technicians, and physician assistants and found that few take advantage of the program, although it is mandatory, because they believe they cannot be spared from their regular duties. Only 20 percent of military physicians had begun a placement in a provincial facility and only 6 percent had completed the program's requirements. Only 43 percent of military nurses had begun a placement in a provincial facility and only 5 percent had completed the program.

4.57 Less than 1 percent of the medical technicians and physician assistants who responded to our survey fully met their maintenance of clinical skills requirements.

4.58 Although base surgeons and clinic managers are responsible for ensuring that all clinical practitioners have maintained their clinical skills consistent with their roles, we found that their personal performance is not evaluated against this requirement.

4.59 Recommendation. National Defence should ensure that it has the information to determine whether all its medical practitioners are qualified to do what they are asked to do and are maintaining their clinical skills.

Department's response. Agree. The Canadian Forces Individual Training and Education System provides the mechanism by which National Defence can ensure that the training provided and qualifications held by its medical practitioners meet employment requirements. This systems approach to individual training and education incorporates cyclical analysis, design, development, conduct, evaluation, and validation phases to ensure that the qualifications attained by health care providers meet both operational and clinical requirements. National Defence remains committed to the use of this mechanism; however, given existing staffing levels within the Canadian Forces Health Services, full implementation of the Canadian Forces Individual Training and Education System has not been possible. Optimal staffing levels will need to be established and staffed to ensure ongoing adherence to the model.

4.60 Recommendation. The Department should ensure that all its medical practitioners who deliver patient care have licences in good standing from the appropriate regulatory body or are certified by their professional association.

Department's response. Agree. The Department currently collects data on the credentialing status of dentists and pharmacists and will establish a centralized credentialing cell to collect data on the status of licensing of Canadian Forces medical officers and public service physicians. This information will be entered into a central repository. Collection of data on licensing and certification for other health care professionals will be undertaken once the physician database has been completed. At present, the tool is a stand-alone database, although the Department will look at incorporating this information into a higher-level corporate system such as MonitorMASS. The third-party contractor must provide evidence of licensure and good standing for all medical practitioners hired as contractors to work in the Canadian Forces health services system.

4.61 Recommendation. National Defence should ensure that where gaps in clinical skills are identified, that action is taken to close these gaps in a timely manner and results are monitored.

Department's response. Agree. Development and maintenance of clinical skills programs is already well underway for all National Defence clinical professions. Adherence to the programs will be assessed through the use of a structured maintenance of clinical skills tracking tool that is currently under development. In the interim, the collection of data from individuals, clinical practice leaders, and financial sources will be used to provide maintenance of clinical skills compliance measures. The foregoing aside, attainment of the required levels of skills maintenance remains problematic due in large measure to the current operational tempo and shortages of clinicians. This has resulted in a longer training regimen for high readiness personnel to ensure that they have the necessary skills for deployment. This will remain a problem until either the operational tempo subsides or personnel deficiencies are resolved. When gaps in skills are identified, senior practice leaders will develop appropriate programs to close the gaps in a timely manner. For example, since many civilian institutions do not see large numbers of patients with severe traumatic injuries, the Canadian Forces Health Services utilizes simulators in many of its training programs.

Clinics are being accredited but the process lacks independence

4.62 In 2000, the Department began an initiative under Rx 2000 to develop and implement a Health Services Accreditation Program to have its clinics accredited and provide assurance that they meet Canadian standards. We expected that this program would be conducted by peers outside the Department through an external accrediting agency, recognized nationwide. We found that the accreditation process was conducted by a well-recognized agency, but the process did not permit a fully independent evaluation of military health care facilities. National Defence required that half of the examiners accrediting the clinics be military health care practitioners because it felt they would better understand the Canadian Forces health system. While it may be that clinics are meeting Canadian standards, the accreditation process used did not provide fully independent assurance.

4.63 We found that all nine clinics that were reviewed were accredited, even though significant differences existed among them in terms of how well they met Canadian standards. As a condition of accreditation, some clinics were required to address high-risk areas

and, at the time of the audit, action plans had been developed to make the necessary changes.

4.64 Recommendation. National Defence should have an independent mechanism to oversee the accreditation of clinical services and ensure that standards are met.

Department's response. Agree. Accreditation survey teams will now comprise independent surveyors to eliminate any potential for real or perceived bias.

Governance and oversight

4.65 Despite departmental efforts to rethink how it delivers health care, senior officials told us that a clear strategic direction and accountability for the delivery of services are still issues a decade after the Department identified these concerns. We noted that management must resolve the competing demands between operational requirements and health services priorities. However, health care system senior managers have little influence on some factors that impact how health care services are delivered; for example, setting service levels according to appropriate demands and costs.

4.66 We found that the military health care system is providing service to military members that they are satisfied with, but there is little oversight to ensure that patient needs are met and services remain comparable to those provided to other Canadians, in a cost-effective manner. There is no mechanism to monitor the system's ability to deliver the required services or to allow system users to challenge the services. The Department does not have a mechanism that brings together all three key stakeholders—health care senior management providing services, military members using the services, and senior military leaders with operational requirements—to provide necessary guidance and provide a basis for accountability.

4.67 Recommendation. National Defence should examine the accountability framework for its health care system to provide better oversight.

Department's response. Agree. The Department will introduce a governance model for the Canadian Forces Health Services system.

Conclusion

4.68 In principle, Regular Force members have access to a full range of health services either within National Defence or through the provincial health care systems. Overall, the majority of the Regular Force members who sought care within their clinics were satisfied with the care they received and with waiting times for clinical appointments.

4.69 While we recognize that military members are satisfied with their health care, National Defence was unable to demonstrate how it assured itself that it was providing its members with quality medical care. Because of a lack of information from which to monitor the delivery of health care, the Department was unable to provide assurance that it was meeting standards and expectations of practice that are indicators of quality health care.

4.70 Mental health services are changing to address growing needs. A model was developed to provide quality care based on best practices. Unfortunately the Department has not been able to staff its mental health services with all the professionals required by the model. Due to this resource shortage, the system cannot meet all the demands for mental health services. As a result, members are being sent to the civilian private practitioners where it is difficult for the Department to monitor their care. Some mental health services are being provided to recognize the moral obligation to help families but these are also facing resource shortages.

4.71 We expected to see a performance measurement system that would provide reliable, valid, and complete information on the performance of the Canadian Forces Health Services. We found that the Department does not have a performance measurement framework to provide reliable information on how the health care system is performing, whether levels of service are appropriate to medical and operational needs, or whether the costs of providing services are reasonable. As a result, information for senior management has been ad hoc and difficult to generate.

4.72 The Department does not yet have a quality assurance program or medical record review practice to ensure that all patients are treated according to current standards of care, consistently and everywhere.

4.73 We expected that all health care providers in National Defence would be licensed and/or certified, and have maintained their clinical skills and qualifications. However, National Defence is unable to

demonstrate that all of its military health care professionals are licensed or certified or have maintained their qualifications to practise.

4.74 Given the healthy status of most military members, many military health care providers are not exposed to a full scope of medical practice that would allow them to maintain their skills. Therefore, National Defence created a Maintenance of Clinical Skills Program to provide the opportunity to practise in a civilian health care facility where military medical professionals can have more exposure to emergency and trauma care. However, we identified very few military medical staff who had completed this program.

4.75 The accreditation process for the military clinics has not been shown to have been fully independent. We expected to see an accreditation process that would be done by external objective reviewers. However, 50 percent of the examiners were military medical professionals. All clinics that we reviewed were accredited, although there were significant differences in standards of care among clinics.

4.76 Ten years after the Department first identified a need to provide oversight of its health care system, there is still no mechanism that brings together all stakeholders to provide guidance and a basis for accountability.

About the Audit

Objectives

The objectives of the audit were

- to determine whether National Defence can demonstrate with reasonable assurance that its physical and mental health care system can provide military members with timely, consistent access to quality health care in Canada; and
- to determine whether National Defence can ensure that the Canadian Forces health care providers are qualified and can maintain their licensure and currency in their clinical skills to provide health care in Canada at Canadian standards.

Scope and approach

We wanted to determine whether necessary measures were put in place based on best practices that provided assurance on whether the Canadian Forces health care system delivers quality physical and mental health care in Canada, tailored to meet operational requirements and appropriate to members' needs.

We reviewed documentation produced by the Department to reform and manage the health care system. We conducted interviews and meetings with representatives from the Canadian Forces Health Services national and operational headquarters as well as at bases to ensure we had a good understanding of the Department and its health care system.

To understand how the Canadian Forces delivers care in the field, we visited medical clinics that have implemented the new model and others that have not, on bases representing 50 percent of the potential clientele of the Canadian Forces health care system. We visited Canadian Forces Bases Gagetown, Halifax, Greenwood, Valcartier, Ottawa, Petawawa, Edmonton, and Esquimalt. We also visited the five base clinics in Canada specialized in the treatment of operational stress injuries.

The clinics we visited were Canadian Forces Type IV and V Medical Clinics, which are stand-alone medical clinics providing comprehensive primary care services and a number of diagnostic and therapeutic services on site.

We reviewed data at headquarters and clinics on accessibility, continuity, safety, appropriateness of care, and cost of care delivery. We also examined the governance of the health system and the accountability of the Canadian Forces to report on the health system performance.

We conducted a random sample survey of three of the largest groups of military health care providers (physicians, nurses, and medical technicians, including physician assistants). The sample was representative with 180 surveys sent. A total of 51 surveys were returned by the physicians, 40 by the nurses, and 40 by the medical technician group. The respective response rates were 86 percent, 68 percent, and 68 percent. The overall response rate was 74 percent. Non-sampling error due to non-response was of moderate concern.

We did not include in our audit the dental services or the health care provided to Reserve Force members or others who are not part of the Regular Forces, nor did we examine patient medical files.

Criteria

We expected to find that the following criteria were being employed by National Defence:

- The Department should have measures in place, including structures, policies, and practices, that provide information on how the Canadian Forces health care system delivers care and on the level of care provided.
- The Department should monitor and evaluate the delivery of health care to ensure it meets its own health care objective “to sustain high quality health care to [Canadian Forces] members in an ever changing environment.”
- The Department should have in place appropriate policies, programs, planning, and practices that ensure the Canadian Forces health care providers are qualified and maintain their licensure and clinical skills in order to provide members with health care at Canadian standards.

Audit work completed

Audit work for this chapter was substantially completed on 1 June 2007.

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Appendix List of recommendations

The following is a list of recommendations found in Chapter 4. The number in front of the recommendation indicates the paragraph where it appears in the chapter. The numbers in parentheses indicate the paragraphs where the topic is discussed.

Recommendation	Response
Monitoring health care delivery	
<p>4.30 National Defence should identify those health care indicators to be used to measure whether it is providing quality care to Canadian Forces members. (4.23–4.29)</p>	<p>Agree. The Canadian Institute for Health Information and Statistics Canada have worked with numerous stakeholders in recent years in an attempt to gain national level consensus on both primary health care and population health indicators. The primary health care list published in 2006 includes 105 indicators and requires numerous survey and data collection tools for calculation. Over the next year, the Canadian Forces Health Services will select an initial core set of indicators that can be compiled from current data sources. These will be in keeping with pan-Canadian health indicators. In addition, the Canadian Forces Health Services will consult with key stakeholders to determine which of the many potential indicators should be used to report on the health of Canadian Forces members and the performance of the Canadian Forces health care system.</p>
<p>4.31 National Defence should develop a system that will provide it with the necessary information it needs to measure its performance against the indicators it establishes. (4.23–4.29)</p>	<p>Agree. The Department currently collects data from myriad sources including the Health and Lifestyle Information Survey, recruit questionnaires, patient satisfaction surveys, the mortality database, health data for deployed operations using the EPINATO database, the Canadian Forces sick leave database, survey reports from the Canadian Council on Health Services Accreditation, and internal reports based on visits to clinics and units by headquarters staff. However, the synthesis of this information into a unified picture of performance against predefined indicators is lacking. Maturation of the Canadian Forces Health Information System will help immensely in this regard.</p>

Recommendation	Response
<p>4.39 The Department should ensure that the levels of service provided at clinics and the associated costs are clearly linked to patient requirements and operational needs. (4.32–4.38)</p>	<p>The Department will also reconsider inclusion of the Canadian Management Information System standards within the Canadian Forces Health Information System project or funding of this tool as a separate initiative. Using the Management Information System standards, which were developed by the Canadian Institute for Health Information, will provide a framework for the collection and reporting of day-to-day financial and statistical data. In addition, over the next two years, the Department will institute a performance measurement and decision support capability to build the capacity to collate data and assess performance against indicators.</p> <p>Agree. In order to ensure that the levels of service provided at clinics are linked to patient requirements and operational needs, the Canadian Forces Health Services will introduce service delivery standards and utilize various tools to measure the effectiveness of the health services system. Civilian service delivery standards will be used as appropriate; however, they may need to be modified to take into account operational requirements. Other standards, unique to the needs of military personnel or that reflect the operational context of a military health care system, will also be developed.</p> <p>Much work has already been done through the Rx 2000 Project to determine resource requirements and implement effective service delivery structures. Implementation and validation of the Primary Care and Mental Health models is ongoing, and the Canadian Forces Health Services workload management system is being modified to provide a more accurate reflection of clinical and operational workload. Using data already available from the Canadian Forces Health Information System and other tools, it will be possible to objectively measure indicators of service delivery.</p> <p>The Department has also taken action to tighten financial controls and manage risk. In the fall of 2006, all civilian and military managers in the Department were required to complete an online knowledge assessment in the areas of financial management, human resources, procurement, and information management. This directive was applied to healthcare clinic managers and the Department will ensure that all new clinic managers will undertake this knowledge assessment.</p>

Recommendation	Response
<p>Quality of health care provided</p> <p>4.59 National Defence should ensure that it has the information to determine whether all its medical practitioners are qualified to do what they are asked to do and are maintaining their clinical skills. (4.40–4.58)</p> <p>4.60 The Department should ensure that all its medical practitioners who deliver patient care have licences in good standing from the appropriate regulatory body or are certified by their professional association. (4.40–4.58)</p> <p>4.61 National Defence should ensure that where gaps in clinical skills are identified, that action is taken to close these gaps in a timely manner and results are monitored. (4.40–4.58)</p>	<p>Agree. The Canadian Forces Individual Training and Education System provides the mechanism by which National Defence can ensure that the training provided and qualifications held by its medical practitioners meet employment requirements. This systems approach to individual training and education incorporates cyclical analysis, design, development, conduct, evaluation, and validation phases to ensure that the qualifications attained by health care providers meet both operational and clinical requirements. National Defence remains committed to the use of this mechanism; however, given existing staffing levels within the Canadian Forces Health Services, full implementation of the Canadian Forces Individual Training and Education System has not been possible. Optimal staffing levels will need to be established and staffed to ensure ongoing adherence to the model.</p> <p>Agree. The Department currently collects data on the credentialing status of dentists and pharmacists and will establish a centralized credentialing cell to collect data on the status of licensing of Canadian Forces medical officers and public service physicians. This information will be entered into a central repository. Collection of data on licensing and certification for other health care professionals will be undertaken once the physician database has been completed. At present, the tool is a stand-alone database, although the Department will look at incorporating this information into a higher-level corporate system such as MonitorMASS. The third-party contractor must provide evidence of licensure and good standing for all medical practitioners hired as contractors to work in the Canadian Forces health services system.</p> <p>Agree. Development and maintenance of clinical skills programs is already well underway for all National Defence clinical professions. Adherence to the programs will be assessed through the use of a structured maintenance of clinical skills tracking tool that is currently under development. In the interim, the collection of data from individuals, clinical practice leaders, and financial sources will be used to provide maintenance of clinical skills compliance measures. The foregoing aside, attainment of the required levels of skills maintenance remains problematic due in large measure to the current operational tempo and shortages of clinicians. This has resulted in a longer training</p>

Recommendation	Response
<p>4.64 National Defence should have an independent mechanism to oversee the accreditation of clinical services and ensure that standards are met. (4.62–4.63)</p>	<p>regimen for high readiness personnel to ensure that they have the necessary skills for deployment. This will remain a problem until either the operational tempo subsides or personnel deficiencies are resolved. When gaps in skills are identified, senior practice leaders will develop appropriate programs to close the gaps in a timely manner. For example, since many civilian institutions do not see large numbers of patients with severe traumatic injuries, the Canadian Forces Health Services utilizes simulators in many of its training programs.</p> <p>Agree. Accreditation survey teams will now comprise independent surveyors to eliminate any potential for real or perceived bias.</p>
<hr/> <p>Governance and oversight</p>	
<p>4.67 National Defence should examine the accountability framework for its health care system to provide better oversight. (4.65–4.66)</p>	<p>Agree. The Department will introduce a governance model for the Canadian Forces Health Services system.</p>

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