EVIDENCE
Whitehorse, Yukon
Wednesday, October 17, 2012 — 10:00 a.m.

Ms. Hanson: My name is Elizabeth Hanson, and I'm now prepared to welcome all of you this morning. I will call to order this hearing of the Standing Committee on Public Accounts of the Yukon Legislative Assembly.

The Public Accounts Committee is established by Standing Order 45(3) of the Standing Orders of the Yukon Legislative Assembly. This Standing Order says that: "At the commencement of the first Session of each Legislature a Standing Committee on Public Accounts shall be appointed and the Public Accounts and all Reports of the Auditor General shall stand referred automatically and permanently to the said committee as they become available."

On December 7, 2011, the Yukon Legislative Assembly adopted Motion No. 7, which established the current Public Accounts Committee. In addition to appointing members of the committee, the motion stipulated that the committee shall "have the power to call for persons, papers and records and to sit during intersessional periods."

Today, pursuant to Standing Order 45(3), and Motion No. 7, the committee will investigate the Auditor General of Canada's report entitled *Yukon Health Services and Programs — 2011, Department of Health and Social Services*.

I would like to thank the witnesses from the Department of Health and Social Services for appearing. I believe Mr. Whitley, Deputy Minister of the Department of Health and Social Services, will introduce these witnesses during his opening remarks. Also present today are officials from the office of the Auditor General of Canada. They are Jerome Berthelette, Assistant Auditor General, and Eric Hellsten, Principal in the Vancouver regional office.

I would now like to introduce the members of the Public Accounts Committee. So, as I said earlier, I'm Elizabeth Hanson, the Chair of the Committee and Member of the Legislative Assembly for Whitehorse Centre. To my right is Stacey Hassard, who is the committee's Vice-Chair and the Member for Pelly-Nisutlin. To Mr. Hassard's right is the Hon. Scott Kent, the Member for Riverdale North. To my left is Patti McLeod, Member for Watson Lake. To Ms. McLeod's left is Jan Stick, the Member for Riverdale South. Behind me is the Hon. Mike Nixon, the Member for Porter Creek South, and to Mr. Nixon's right is Darius Elias, the Member for Vuntut Gwitchin. The Clerk to the Public Accounts Committee is Floyd McCormick, who is also the Clerk of the Yukon Legislative Assembly.

The Public Accounts Committee is an all-party committee with a mandate to ensure economy, efficiency and effectiveness in public spending — in other words, accountability for the use of public funds. The purpose of this public hearing is to address issues of the implementation of policies — whether programs are being effectively and efficiently delivered — and not to question the policies of the Government of Yukon. In other words, our task is not to challenge the government policy, but to examine its implementation.

The results of our deliberation will be reported back to the Legislative Assembly. To begin the proceedings, Mr. Berthelette will give an opening statement summarizing the findings in the Auditor General's report. Mr. Whitley will then be invited to make an opening statement on behalf of the Department of Health and Social Services.

Committee members will then ask questions. As is the committee's practice, the members devise and compile the questions collectively. We then divide them among the members. The questions each member will ask are not just their personal questions on a particular subject, but those of the entire committee.

At the end of the hearing, the committee will prepare a report of its proceedings and any recommendations that it makes. This report will be tabled in the Legislative Assembly along with a transcript of the hearing.

I would like to make a comment and a request before we do start this hearing that people endeavour to make sure that the questions and answers be kept brief and to the point so that we may deal with as many issues as possible in the time allotted for this hearing.

I would also ask that members, witnesses and advisors wait until they are recognized by the Chair before speaking. Hopefully, this will keep the discussion more orderly and allow those listening on the radio or over the Internet to know who is speaking.

We will now proceed with Mr. Berthelette's opening statement.

Mr. Berthelette: Thank you for the opportunity to discuss our February 2011 report on Yukon health services and programs. With me today is Eric Hellsten, Principal. I would just like to note that also here today are Ronnie Campbell, Assistant Auditor General and Charlene Taylor, Director.

Madam Chair, virtually every person in Yukon will access the Yukon health care system several times during their lives. In the 2009-10 fiscal year, the Yukon Department of Health and Social Services spent about $148 million on Health Services and $109 million on Social Services, Continuing Care and Corporate Services. It is the largest department of the Government of Yukon.

Health Services expenses have grown by 47 percent over the past five years. Increasing costs mean that health care has taken a greater percentage of the government's overall expenses. Several factors make the delivery of health care challenging in Yukon. While the majority of Yukoners live in Whitehorse, about 8,500 live in small, remote communities. The overall population in Yukon is growing. It has grown by 8.1 percent since 2005 and the 50-plus age group is growing even faster.

The incidence of chronic conditions increases with age and will have an impact on the cost and delivery of health care. The audit mainly covered the 2005-06 to 2009-10 fiscal years, and audit work for this chapter was substantially completed on September 15, 2010.

In our audit we looked at whether the department regularly identified health priorities and developed or modified programs and services to address them. We also examined whether the department could demonstrate that it incorporates adequate strategic planning into the delivery of health services and programs. Finally, we looked into whether it measures, monitors and reports on performance and results. We specifically focused on the diabetes program and the alcohol and drug services program because diabetes and alcohol and drug abuse can lead to serious health complications.

Generally, we found the department has started to make a transition to more formal management systems and processes. To set direction for the health care system overall, the department has begun putting into place processes for strategic planning and risk management, but these are in the early stages. We found that the department did not establish key health indicators and targets for health outcomes and it did not have a comprehensive health information system to collect complete and accurate data needed for planning and risk assessment.

To manage human resources, the department had policies and procedures in place, as well as demographic analysis; however, it did not have a corporate human resource plan to manage current and future needs. Without a plan, the department could not assess whether it was allocating resources in the most effective way.

Looking at the diabetes program and the alcohol and drug services program, we found that objectives were not specific and measurable. There were no indicators, outcomes or measurement processes in place for either program. As a result, the department could not monitor performance, assess the progress of programs or report on their effectiveness.

We found two evaluations for the diabetes program, but they were of limited use because there were no measurable objectives or targets. This made it impossible to evaluate progress or success. There were no evaluations for the alcohol and drug services program.

In summary, Madam Chair, we found that the department had not identified and formally documented its most important health priorities or adjusted programs and services to reflect these priorities. It did not use or analyze data from all relevant sources to determine whether its programs and services were meeting objectives or reaching those people who need them, nor did the department publicly report to Yukoners.

We made 11 recommendations in our report. The Department of Health and Social Services agreed with our recommendations, and we have included their responses in the report.

Madam Chair, this concludes my opening statement. My colleague and I would be pleased to answer any questions that the committee members may have.

Ms. Hanson: I will now call upon Mr. Whitley from the Department of Health and Social Services.

Mr. Whitley: Good morning, members of the committee, and colleagues from the Auditor General's Office. I am the Deputy Minister of Department of Health and Social Services, and I consider this an important aspect of my responsibilities to be here to address you and to answer your questions in respect to the Auditor's report.

Before I speak briefly to you, by way of overview, I want to introduce the senior members of my team who are with me today.

To my left is Birgitte Hunter, the Assistant Deputy Minister for Corporate Services. To her right, is Sherri Wright, who is the ADM responsible for Health Services. On my left is Cathy Morton-Bielz, the ADM responsible for Continuing Care, and to her left is Dorothea Warren, who is responsible for Social Services.

Almost directly behind me is Jan Langford, who is the acting director for the wellness initiative. We will talk about that in a bit. To her right is Christine Paradis who is the Executive Director of the Social Inclusion initiative, which we will talk about as well in a moment; and to her right is Brian Kitchen, who is wearing a tie this morning. To my left behind us is Kathy Frederickson, Director of Corporate Planning and Risk Management; and to her left is Brian Farrell, Director of Human Resources. Without these people I couldn't possibly keep within my mind all of the information that is necessary to impart to you this morning.

I want to express my thanks as well to the people who invested an enormous amount of effort, not only during the audit process, but in the post-audit process with the implementation of the recommendations, and in fact, the considerable amount of work that has gone into simply preparing information to present to you — hopefully in a coherent way this morning.

We are going to explore, quite obviously, many of the issues as we go through the report. The report, as you know, lists 102 findings — I would call them — and made 11 recommendations flowing from them. As you already know, we've accepted all the recommendations that were made by the Auditor General. In fact, I should point out that, from strictly a management point of view — particularly an arm's-length audit — is always welcomed as it affords us the opportunity to reflect on our work and improve it.

I want to speak to you about the sustainability of the health care system and the need for change in the health care system, and the fact that that issue is front and centre for all Canadians. There are many issues that differentiate northerners, particularly Yukoners, from the rest of Canada. One of them is our demographics. The sheer fact of the matter is that our population is small — 35,000 people or so equates barely to a blip in a big jurisdiction.

You all have copies of my remarks, which I'm going to try and stick to as closely as possible, but there's a reference to the two solitudes that traditionally used to be French and English, but now it's suggested there are becoming two solitudes — one north and one south. There are references in my notes to the young demographic in the north — not so much in the Yukon, but nevertheless a matter of concern for us.

We know from our history what a northern future holds in terms of our health care challenges — mines and industry, population influx, environmental change and risk, dislocation — and these all lead to a host of accompanying social and

health problems. These economic and environmental changes will have significant effects, both positive and negative, on the well-being of Yukon communities and families and, by implication, young people in the Yukon.

But with respect to health care, we urgently need to be acting now. Children are our future — that's a bit of a cliché — but their well-being today predicts the health of adults 20 years down the road — and commensurately so for health care systems in the not-too-distant future. The focus in Canada has been to spend money on the back end of the health care system, and the acute care system tends to draw much more money than the kind of upstream interventions we are going to speak about in a moment.

About the same time as the Auditor General's report was released, there was also a study released called *Health and Health-related Behaviours Among Young People in Yukon*, which is part of a national study. Though each province and territory had its own report, the one that was released in our jurisdiction raised grave matters of concern. While there is some good news regarding youth health and well-being, there are some bleak observations. It's clear that the broader context of increased access to junk food, direct marketing to children and youth, glorification of violence and bullying, exclusion and humiliation as entertainment, reality shows and video games — and I would add, in light of what's happening currently — social networking has a negative influence on children's lives. All of these things are having an effect on the health of children as much as is the traditional understanding of poverty.

In the north, our kids are no better protected from these influences than their peers in the provinces, but the impacts are often disproportionately worse because of the lack of appropriate programming or resources or other options that tend to — or can — counter such negative influences.

We have high levels of hunger in the territory, with 42 percent of boys in grades 6 to 8 reporting that they attend school or go to bed hungry; poor eating habits and fewer meals with families and kids pondering leaving home with as much as 40 percent of kids in rural Yukon having contemplated running away. There are high levels of bullying, and 20 percent of boys in grades 6 to 8 and 35 percent of girls in grades 9 and 10 feel they're being taken advantage of. There are also alarmingly high rates of smoking, binge drinking, drug use and reckless sexual activity, all of which have an enormous impact on our health care system — not necessarily so much at the moment, but certainly downstream.

On most indicators of well-being, rural children fare worse — and in some cases, much worse — than children living in Whitehorse. This is a wellness gap, and it underscores the challenge of promoting positive youth development in very small, isolated communities where there may be only a handful of young people and few, if any, opportunities to direct their time, energy and interests in positive ways.

These risk factors, behaviours and patterns will have serious health repercussions in later life, to say nothing of their impact on future health care costs or our ability to meet rising demand for services. Moreover, children who are sleep deprived, hungry, stoned or hungover cannot learn. The jobs of a prosperous north require a workforce that is literate, thoughtful and competent. If we want our children to benefit from the new northern economy and be better protected against the adverse impact of development, we have to act now in a manner that transcends simple, if urgent, questions of spending.

Another aspect of the northern reality that bears on the issue of health care delivery is our sparse population, often scattered at great distances in remote places, one of which is only serviced by air. There are few economies of scale in the north so programs that are mounted in Whitehorse simply can't be carried out distantly in some of these small communities, even as smaller images of the parent project. We are about one-tenth of the size of the smallest health authority in British Columbia — which is the Northern Health Authority — just to put that into perspective — and we're roughly the population of Campbell River, a community located in a health authority which provides services to three-quarters of a million people.

This geographic dispersion affects not only health care delivery, it also brings a range of other challenges. For example, access to proper nutrition is difficult and expensive and this issue was raised publicly only recently — much more often than recently, but certainly it has been raised in recent days.

As aboriginal populations have moved away from traditional food, there has been an increased reliance on processed foods and other less desirable consumables. In consequence, diabetes and other nutrition-related diseases have become more prevalent. Add to these difficulties limited access to health care professionals, poverty, cultural and language barriers, heavy smoking rates, lower life expectancies and serious mental health problems that have little chance of early detection or treatment, and the obstacles to delivering a reasonably equitable level of care to many Yukoners can seem quite daunting, especially for a small jurisdiction, let alone for any sense of how we are going to pay for increased costs of solutions to address these issues.

This leads me to the next key challenge, which is health care system financing. Yukon, like all other provinces, depends upon federal transfer payments to fund our health care. However, in the north where there are smaller tax bases for generating revenue and the delivery of services is costlier, these federal payments are central to the sustainability of our health care system.

Though these payments are generous — there is no debating that — they are only sufficient to set a minimum service floor. They do not afford a margin for experimentation or innovation.

The supplement of the territorial health system sustainability initiative — or THSSI, as we call it — which is provided to the territory in recognition of the additional challenges faced in the north, creates some room to try new and different things. This is episodically augmented by some project funds from the Public Health Agency of Canada and the occasional spot funding from Health Canada. All of this is time-limited or one-off funding. THSSI funding was scheduled to end last year. Mercifully, the federal government has continued it until 2014, dur-

ing which time the government will enter into negotiations for a renewal of the Health Care Accord. I will say more about that later as we go along in the questioning.

If THSSI is not renewed or put into our base, how we will manage that drop in funds is a matter of concern for us.

In some respects, this unpredictability in funding has led us to become a region of pilot projects. This is a complaint right across the north and, in fact, across northern Canada and in the provinces. There is a really cruel perversity to pilot projects. We're anxious for any opportunity to have funding to try new things, and even though we are certain — near certain — that experimentation will lead to something worthwhile, we have a lot of anxiety about what will happen when the funding drops at the end of the year. A perfect example of that was the mental health workers in the communities. The horizons of narrowly funded projects are seldom long enough to make a difference on a macro level beyond the initial glow of promise. The centrifuge of the acute care apparatus — its gleaming technology, miracle drugs and its implicit covenant that no matter what befalls our bodies, self-inflicted or otherwise, there is a cure and it will be taken care of — takes up the lion's share of funds. This leaves less glamorous, more difficult-to-measure initiatives quite far behind.

This is a central point to my introductory remarks, and one that touches upon the Auditor's initial observations about priorities. The department believes that the only way to make a permanent and significant difference in the cost of health care is to change our attitudes about what constitutes healthy living.

We know already that the social determinants of health are the most powerful indicators of health and well-being, present and future. This observation was made in 1970 in a royal health care report by a Cabinet Minister, which was the Lalonde report. Based on the evidence adduced before that commission, it was clear that the most powerful indicators of health outcomes were the social determinants of health.

We know already what the downstream consequences of smoking, alcohol and drug abuse, poor diet and stress will have on our health outcomes, quality of life and productivity, to say nothing of the burden it poses on our emergency room. Lately, we have come to know the looming horror implicit in the notion that for the first time in human history, this generation of children cannot expect to live longer than their parents. No amount of glistening acute care systems is going to change that fact, but only a sustained and significant shift in our understanding of what it will take to innovate and transform our health care system will leave us well positioned to address these challenges. This is why we made social inclusion and wellness our most important priorities. I have to say that those priorities were established some three years ago. We have put considerable amount of thought into how we are going to develop both of those priorities, and we will speak to that more as we go along.

There are three general themes in the report. The first has to do with planning and setting priorities. The second involves, very generally, data collection. The third addresses evaluation and performance management with a focus on the diabetes and alcohol and drug program. We have agreed with the recommendations of the auditors, and I will be very happy to report on progress that we've made so far with respect to some of them as we go through each one during the questions.

I do want to comment briefly on a couple of the summarized points made by the auditors in their opening remarks. I would like us to bear in mind as we go along something that I think everyone opposite understands full well. Nevertheless, I think it's worth saying that we are both a ministry and a department. We don't have health authorities, so we are largely responsible for programming, which as each of the committee members understands quite well, invariably gets the primary attention.

What the human and fiscal resources at health authorities in British Columbia, for example, can dedicate to collection analysis and reporting on measures of health and health-related behaviour is far in excess of what we in the Yukon can do — or, quite frankly, can ever do — as long as our population base remains close to what it is. For example, in our alcohol and drug program, we commenced a project to develop standards based on best practices and evaluation processes based on benchmarks and targets. This was a three-year program. We're in the last year of that program. It was funded by Health Canada, and you can see in the notes before you that the cost was approximately $1.8 million — that's just for one program, albeit an important and central program.

In closing this interview, I'd like to briefly mention the reference and the introduction of the report to the overruns. There are three important things to bear in mind regarding the issue of the overruns in those two years. First of all, while we are, of course, bound by the *Financial Administration Act*, we are obliged by other statutes — the *Health Care Insurance Plan Act* and the *Travel for Medical Treatment Act* — to provide services.

The language is mandatory. We are not free to ignore the dictates of legislation that require us to tend to the health and welfare of Yukon citizens by simply saying, "I'm sorry, we don't have any money." I admit that it is possible to go back to government and ask for more money — which we have in fact done from time to time — but the second cost driver — and it is probably more important in relation to those two years — is that we rely on acute care health delivery services from jurisdictions outside Yukon, principally British Columbia, but also Alberta. The protocol that we have with these jurisdictions allows them to bill us up to 12 months after the close of the fiscal year. So it is not only conceivable, but sometimes the reality, that we don't know what patients are in other jurisdictions or whether or not their diagnostic analysis has changed or whether or not their treatment program has changed significantly.

But even for that, the host jurisdiction is entitled to bill us up to 12 months afterward. So we sometimes get bills that are in the millions for patients who have been treated for various things outside the territory.

The way in which we traditionally address these matters, if we know about them, is to seek supplemental funding, rather than incremental increases as we go along. I've given a number

there — the intensive care bed costs us $5,000 a day. So you can imagine that the average stay in intensive care is somewhere between nine and 14 days — how quickly that can add up. Then it goes up even further, depending on the complexity of the treatment that's necessary.

So the point is worth repeating — we're not a large jurisdiction, and sometimes the numbers are skewed by factors that aren't even rounding errors in other jurisdictions.

That concludes my opening statement. I want to thank the auditors for working with us. I won't say it was completely free of bumps and grinds.

We did have our disputes, but at the end of the day, I think that their observations have enabled us to make some course corrections in the work that we're doing and we view them as measures that will improve our work and the service that we have for Yukoners. I have some other generalized comments to make, but I'll make those as we go through the questions.

Ms. Hanson: Thank you, Mr. Whitley. I just wanted to point out that I neglected to detail what the schedule will be today. We will be meeting until noon and then taking a break until 1:30 and continuing. We are currently scheduled until 3:30, but that depends on how long it takes us to go through the questions.

Just to pick up on your comment, Mr. Whitley, you'll find that the committee has based the questions that we've prepared for this meeting today on the findings and the 11 recommendations made by the Office of the Auditor General. The approach that we'll take is that each of the committee members will be identifying some of the findings and, based on those recommendations, we'll go through those and they'll be asking a series of questions based on that particular sort of thematic area. We'll commence to my left with Jan Stick. As I'd said earlier, I'd ask that members of this committee and witnesses or any advisors to wait until they're recognized by the Chair before speaking.

Ms. Stick: Welcome and thank you all for coming. For me this is a first, and I am quite interested in the process today.

In paragraph 35, we have the first recommendation, which reads, "The Department of Health and Social Services should develop and report on performance measures and ensure that risk assessments are based on sound information. In addition, it should develop business cases on a more regular basis." The department's response was that they agreed, and you can read, "The Department is committed to continued participation on the Government of Yukon Interdepartmental working group on the implementation of strategic planning and the development and reporting of performance measurements."

My first question then, coming from this recommendation, would be this: Have criteria been developed to determine where business case analysis and risk analysis are required?

Mr. Whitley: The short answer to that question — actually I don't think there is a short answer to that question other than "Yes", but it needs some elaboration.

We continue to operate on the basis of our strategic plan we developed in 2009 with a five-year horizon. We are working with a new government and the new government's mandate, so we need to adjust according to governmental priorities. There were several performance measures identified in that plan. The department continues to monitor our progress in achieving those measures. One of the important steps that we've taken is to create the position that Kathy Frederickson now holds. She has the responsibility for cross-departmental initiatives, to track them and ensure that they are meeting the objectives that are set out.

The priorities that are established by the department are established through the governance mechanism that we've established in the department. This was a major priority for me when I was hired and given direction by my then minister five years ago to develop a rational governance model that would allow for decision-making to be made in a way that was consistent with planning. Of course, there was not the type of planning that I think the auditors either recognized or approved of at the time. So concurrently, as we have developed the governance structure and to ensure that the right people are in the governance structure, we had to develop a strategic plan.

Also, just to very briefly add a footnote to that, we are continuing to participate on the interdepartmental working group on the development and implementation of strategic planning, which is right across government. We are now offering regular training to all our staff in what "strategic planning" means and the consequences for ensuring that the programs are evaluated.

Sorry, I didn't mean to go on at length, Madam Chair.

Ms. Stick: I just want to point out that we are looking at risk assessments and the performance measurements also.

Can you tell us please if there has been any business case analyses carried out since the release of this Auditor General's report?

Mr. Whitley: There are a couple that I can point to. The first one would be the territorial health funding business case of 2011.

I can actually provide you with a copy of that, if that would be preferable to going through it at length. But, essentially, to make a case now for any federal funding, it has to be predicated by the preparation and delivery of a business case that is satisfactory to their financial analysts. That was done in 2011. The chronic condition support program that we ran in August 2011 — also federal money — had a focus on diabetes. That was also a business case that was done.

Just one last comment I'd make — we have done a risk-assessment profile for the department, and that was part of the creation of that office. That was the first responsibility for that incumbent.

Ms. Stick: You have answered the next question, so I'm going to move on. Is the department finding any obstacles to conducting business case analyses on a more regular basis?

Mr. Whitley: Yes. I suppose you want me to identify —

Ms. Stick: Yes.

Mr. Whitley: Obviously, there is a resource issue. Although we're the largest department in government and we're

often looked at as — "Well, what are you doing with $260 million anyway?"

The fact of the matter is that the department itself is fairly flat in terms of its vertical arrangements. To create a business case is fairly labour intensive. Even to prepare for this committee — to try to anticipate what your questions might be so that we could focus efficiently — required a preparation of this binder and other papers, which involved several weeks of work led by one person, but contributed to by many. It's a matter of us trying to decide on a prioritized basis — and that goes back to the governance structure that we have. We discuss these things in our meetings about whether or not we can afford to take someone off another project and put them on a particular project. I would say that resources is an issue.

A second, somewhat related issue to this is the fact that I alluded to earlier — that we have many opportunities to access federal funding through the Public Health Agency of Canada, or PHAC, or the Department of Health.

But these are time-limited projects, so the expectation is that we'll get going on them fairly quickly. There is not a lot of data we're able to access to make the case for this money. The whole purpose of pilot projects is to ask: Is there a gap, and how can it be most effectively filled? So many of our business cases are made after the fact — after the project is done, which is not the best way to go about preparing that sort of thing.

That's kind of the core of what stands in our way.

Ms. Stick: In your response to this recommendation, the department says that it was committed to continuing participation on the Government of Yukon interdepartmental working group on the implementation of strategic planning and the development and reporting of performance measurements. Can you elaborate on the department's participation in the process?

Mr. Whitley: We have regular participation on that interdepartmental committee. Kathy Frederickson, whom I referred to as the person responsible for our corporate initiatives, is a regular participant on that committee. That committee's work is led by the Executive Council Office.

Ms. Stick: I am moving ahead now to paragraph 25 — well, actually going backwards a bit — where, "The Department has identified many health priorities in its planning documents but has neither ranked them nor produced plans to address them that include resources, timelines, and targets. As a result, it is not clear which priorities are critical and what the Department will do to address them." Out of that, we have the next recommendation at paragraph 36: "The Department of Health and Social Services should rank its health priorities, set timelines and targets for addressing them, and identify the resources required."

The department's response was that they agreed and, while the priorities were not ranked formally, it discussed the new wellness strategy and social inclusion and poverty reduction strategy. The social inclusion and poverty reduction strategy was scheduled to be completed that summer and work on the wellness strategy, which had just recently begun, had a target date of completion of March 2013. Other priorities are identified. The first question I have out of this recommendation is this: Does the department now rank its health priorities?

Mr. Whitley: The short answer to that question is that we have not, as yet, ranked the health priorities underneath the general priorities that I identified earlier. The social inclusion and the wellness initiatives are our top two priorities. We have determined that, because of our aging demographic, an aging-well strategy as an aspect of wellness needs to be given serious attention, so that within the overarching objective to improve the wellness of Yukoners, we have decided to focus — and this is spurred in part by the recommendations of the Auditor General — on family, youth and children as the best place to commence work.

The social inclusion and poverty reduction strategy framework has 30 different initiatives within it, spanning multiple government departments. Each one of them has monitoring, reporting and evaluation of performance indicators for each one of those. That leaves me to answer this question: What went into making a determination about wellness as being our priority? We looked at the data of the health status of Yukon people and the inequities in that status between the most healthy and the least healthy people in the Yukon. We looked at the research on prevention and the cost benefits preventing chronic conditions. We looked at the evidence in the proximal and distal risk factors that contribute to illness and injury, and the thinking there is that if we understand the causes of ill health and injury, we can prevent the onset of conditions — at least delay the onset.

We also looked at the research and literature available about what works to prevent illness and prevention. I can elaborate at length on that because I have a fair bit of notes, but there is a process that we follow in determining priorities, and within those broad priorities, looking at what sorts of things we should pay attention to first. There are many, many health conditions that we are tasked with addressing: diabetes, hypertension, heart disease, cancers of many, many different kinds. All of these can be considered health indicators and do get that consideration in other jurisdictions. We haven't ranked those as priorities. Rather, what we are trying to do is bring some cohesion to our priority setting within general umbrellas of concern and then identify priorities within that. For example, if we know that colon cancer in the Yukon seems to be on the rise — and I say "seems to be", because the numbers are so small that when CIHI — the Canadian Institute of Health Information — gets gross numbers from us, multiply our factor by 100,000 it becomes a meaningless number.

But if we have a sense that the numbers of colon cancer in the Yukon are rising, as we do, we want to look at a number of things. One of them is, should we do more explicit and accurate testing? That's one of the things that we're contemplating as a priority from reviewing the data that we do have.

The other point I would make in response to your question, Ms. Stick, is that in the health care review we did back in 2009 there was a strong recommendation that health promotion get more of a focus and that more investment ought to be put into

that. Again, it fed into why we would select wellness as a health priority to focus our attention on.

Ms. Hanson: Thank you, Mr. Whitley. I think we'll find during the course that, instead of questions, there will be an opportunity to elaborate on some of these. I think, with the questions that the committee has put together, there may be an opportunity to be a bit more succinct in some aspects of it.

I am not trying at all to curb the wealth of information that I know that the department has and has prepared, but we are trying to focus particularly on the specific aspects of each of the recommendations.

Ms. Stick: Following up from what you have said, when the department does identify health priorities, how does it produce plans that include your resource timelines and targets?

Mr. Whitley: The production of the plan is the responsibility of the program area, and once again, it goes back to how we conduct our work in the department. We have an executive management committee and above that — if you look at it on a vertical chart — we have a deputy ministers committee and then it would be my office. So at the executive management committee, we have all of the senior directors in the department, which are about 21 or 22.

The proposal comes to that committee first, as a rule, and is reviewed by that body to determine whether or not it is part of the strategic objectives that we have identified ourselves — the operational business plan for the year that flows out of our strategic plan. If it has approval there, then we look at the cost of the initiative and how that will work, what the outcomes will be — which implicitly involve measurables — and then it's taken forward for final approval by the deputy ministers committee. The deputy ministers committee is chaired by me, as is the executive management committee, with the four ADMs of the department. The reason it goes to that department is because we're trying to look at the pressures that we have. Particularly for new initiatives of the kind you're speaking about, we're trying to look at them corporately so that if the program area can't afford to do the particular initiative, we look at the rest of the department to see whether or not there are offsets or potential areas of funding that we can redirect to support the initiative.

Ms. Stick: In part of the response from the department, it stated that work on the wellness strategy just recently began, with the target completion date of March 2013. Can you tell us, please, if the timeline for completion of the wellness strategy is still on target?

Mr. Whitley: Yes.

Ms. Stick: The response also discusses the *Yukon Social Inclusion and Poverty Reduction Strategy* that was scheduled to be completed in the summer of 2011. Was that strategy completed then?

Mr. Whitley: I'm sorry — the reference was to what?

Ms. Stick: The *Yukon Social Inclusion and Poverty Reduction Strategy* being completed in the summer of 2011.

Mr. Whitley: It's not completed yet — no.

Ms. Stick: Does the strategy address the Auditor General's recommendations that the department should rank its health priorities, set timelines and targets for addressing them, and identify the resources required?

Mr. Whitley: Yes, the outcome of that exercise will have those identifiable factors in it. Did you say "social inclusion" or "wellness"? It applies to both.

Ms. Stick: I think it would apply to both.

Mr. Whitley: Yes, it applies to both.

Ms. Stick: Sorry, could you —?

Mr. Whitley: The finished documents will have those priorities, benchmarks and outcomes clearly identified.

Ms. Stick: Thank you. It also said in the response to the recommendation that the department says that priorities may shift in response to urgent health needs of Yukoners — in this case, it was the H1N1 response — or following direction provided by the minister and Cabinet. You have discussed this a little bit, but has there been a similar shifting of priorities since the Auditor General's report of February 2011?

Mr. Whitley: Absolutely. The Auditor General's report required that we focus on the commitments we have made as a result of the recommendations. We have agreed to all of the recommendations, therefore there is an enormous amount of work to be done in just meeting those recommendations. Were you referring to other diversions, such as the H1N1? That was the most significant one that we have had to face — since I've been here, at least.

Ms. Hanson: Any follow-ups, Ms. Stick?

Ms. Stick: Not at this time, Madam Chair.

Ms. Hanson: I should note, too, that we may choose to take an opportunity at the end of the session for follow-up questions as the day goes on.

I would like now to turn to Ms. McLeod, who has some questions.

It's such a nice opportunity to be able to say this to her.

Ms. McLeod: Thank you for joining us today. Paragraph 34 is the area I'm going to start with.

While a risk management structure is in place, the data limitations we identify in this report mean the department's risk assessment decisions may be based on insufficient information and, in addition, performance measures have not been established. My question is this: What is being done to ensure the department has sufficient information to mitigate the level of risk in its decision-making?

Mr. Whitley: We have established risk registers in all of our program areas, and performance measures have been identified in the 2012-13 departmental plan. We have samples, if you care to review them during the break, or they can be provided to you later on, if you wish.

The issue of data limitation is an important one because the state of our systems is not state-of-the-art.

Part of that is historic and part of that is as a result of the devolution from the federal government. Several years ago we inherited, in some instances, systems they were using at the time. So, for example, in Social Services we have a data system that is fundamentally unreliable, in terms of the kind of data production we can get from it in order to do the kind of analy-

sis that the Auditor General expects us — quite rightly — to do.

We are inputting our enterprise risk management data into the central system now that is maintained by the Department of Highways and Public Works, as well as the risk management processes now going to be incorporated on a permanent basis into the strategic planning process, which develops operational plans for each year.

Ms. McLeod: What has been done to establish performance measures that would assist with this?

Mr. Whitley: I'm not entirely sure I follow the question, because our strategic plan and our individual operational plans for the year incorporate performance measures. So, could you be more specific about the question, please?

Ms. McLeod: Well, I guess the question really is this: What is in place to ensure that you're carrying out what you say you are?

Mr. Whitley: Let me give you an example, then, if I may. The diabetes program measures hemoglobin count. So the hemoglobin count for each patient is tracked over the course of the patient's involvement with the program. The higher the hemoglobin count, the more concern we have that the patient is not managing their diet, their exercise — the plan that was laid out for them — in the way that's expected. So we're able to make feedback corrections to the particular patient. So that's a very specific example, but it would be a performance measure to determine whether or not that's actually happening.

Ms. McLeod: Excellent. Thank you.

We are going to move on to strategic plans, paragraphs 22 to 25. In paragraph 23, the report says, "We found that the Department has a five-year strategic plan. The 2009–2014 strategic plan identifies the Department's strategic goals, objectives, strategies, mission, and vision. However, we found that the plan's goals and objectives are not measurable. Nor does the Department identify standards for the level and quality of services or prepare an analysis and selection of alternatives as required by the Financial Administration Manual."

Has the department developed instruments to measure the achievement of the goals and objectives laid out in the strategic plan?

Mr. Whitley: Let me start first of all with the strategic plan itself. The finding that the goals and objectives of the department are not measureable may have been true, and it is generally true of many of the programs that we have, but it is not absolutely true.

For example, in continuing care, which was not an area of examination or scrutiny by the auditors, there was an accreditation process that had commenced several years ago, in 2009, and within the context of the accreditation exercise, goals and objectives and performance standards were all set out. The accreditation process, as you're probably aware, involves ongoing participation from Accreditation Canada so that the goals and objectives that are set out are determined to either be met, not met, or some progress measured toward meeting them.

We are moving as a department — prodded, if you will, by the Auditor General — toward more standardized planning processes and templates, and we will be revising our strategic planning document to ensure that goals and objectives are measurable. The period of time from 2014 to 2019 is the next expected strategic plan time frame when we will ensure that every program that we are involved in has a standardized template that applies. I'll leave it at that for the moment.

Ms. McLeod: We understand that that work is ongoing. Does the department now identify standards for the level and quality of services?

Mr. Whitley: Yes, it does, and I think you should see that in the Cabinet documents now. Our Cabinet documents and submissions for support for programs and expansion of programs will routinely have that as part of the submission.

Ms. McLeod: Does the department now prepare analyses and selection of alternatives as required by the financial administration manual?

Mr. Whitley: Yes.

Ms. McLeod: Paragraph 24 says, "The strategic plan identifies external stakeholders, but the Department does not communicate with them consistently. We found that the roles and responsibilities of key stakeholders, such as First Nations and Aboriginal groups, are not clearly defined. Better communication between these parties is important to ensure that they work together to generate plans for a better overall health status for First Nations and Aboriginal peoples."

Since the release of the Auditor General's report, have the roles and responsibilities of key stakeholders been clearly defined?

Mr. Whitley: In some cases, yes. Let me just elaborate on that briefly. One of the major initiatives that we have in the department, as I have mentioned, is the social inclusion strategy. We have a community advisory committee that involves 13 community and First Nations stakeholder groups. It is an entity that has its role and responsibilities clearly defined in the terms of references set out by mutual agreement, and probably is a model of how community consultation can proceed in a collaborative way.

Another instance of work that was ongoing at the time of the audit was the non-governmental organization funding policy. The practice up until then — and I think the auditors would have found good reason to criticize it — was pretty ad hoc. NGOs would come for funding, either to the department or to the minister, on a random basis and ask for increases that may or may not have been justified.

What we have attempted to do, I think successfully, is to develop a policy that rationalizes that process — that identifies the nature of their responsibilities for the NGOs, and it was a policy that was worked out collaboratively with all of the NGOs meeting with us at the department. There are some others that I could mention, Madam Chair, but I do want to say one thing about the findings about the roles and responsibilities of key stakeholders such as First Nations and aboriginal groups. It is a finding that I think is made in something of a vacuum when it comes to the relationship that exists between First Nations and the department. We don't consider the First Nations a stakeholder group; they're another level of govern-

ment and their relationship with the government proceeds on a very strict protocol. So, the arrangements that we have with them involve at minimum ministerial direction, but always the involvement of the Land Claims and Implementation Secretariat because there are implications that flow from the final agreements. So that's on the one hand.

On the second part, each First Nation will want to proceed according to a different set of priorities, so it's not really open to us to standardize how we will govern our relationships with First Nations. For us to define that might be considered to be somewhat presumptuous. What we need to do with the First Nations is find ways for us to work together where their leadership and our leadership are agreed in that certain principles will apply in respect of particular instances, such as child protection. I can elaborate on that later.

Ms. McLeod: Is your process and procedure the same for those First Nations that do not have a settled agreement?

Mr. Whitley: Yes. The absence of a collective agreement shouldn't lead to a presumption that there won't be one, so it's safer for us to proceed in appropriate deference to another level of government, because there is in fact another level of government, whether or not they do have a final agreement.

In any event, our conduct with First Nations who are not yet settled in their agreements will affect how that agreement will ultimately look. So, necessarily, the Land Claims and Implementation Secretariat is concerned and wants to be involved in how those agreements proceed.

Ms. McLeod: Thank you.

What actions has the department undertaken to improve communications with stakeholder groups, understanding that you don't consider First Nations to be stakeholders per se; however, if we can consider them in that light?

Mr. Whitley: There are a number of vehicles that we have at our disposal for improving our communications with various groups. One example that I can give you is the Health and Social Services Council, which is mandated under the statute to advise the minister on various issues. That council, as you are probably all aware, has a cross-section of Yukoners who provide their views on particular issues to the minister. That is done through the department so that we have a sense of how to manage what is coming from that particular entity.

Another example I can give you is the Yukon Advisory Committee on Nursing, which is a liaison relationship we have with the nurses association. Our liaison attends their meetings regularly, and similarly with the Yukon Medical Association, First Nation health and social commissioners — there are many entities we have to build on how we communicate with them.

Now, there is a fair comment made by the auditor that we don't do it consistently. That is true, because these entities quite often expect — sometimes at least an ADM, and sometimes the deputy minister — to participate and it's simply not possible, given our small size.

Ms. McLeod: Paragraph 4 of the report say, "Aboriginal people experience some of the most significant health disparities in Canada. In 2006, the Yukon Bureau of Statistics reported that the 10-year moving average life expectancy is shorter for the Aboriginal population than for other Yukoners." Given this significant health disparity, what plan does the department have for working together with First Nation governments to generate plans for better overall health outcomes for First Nation and aboriginal peoples?

Mr. Whitley: The issue that you raise is a national one, and we discussed this issue at the national table. What sets us apart is the fact that we have First Nations, most of which have final agreements and have, in many respects, assumed responsibility for some of the population's health issues across the territory. We still manage the acute care aspect of the health care system but in terms of the factors that go into reduced life expectancy, the increased prevalence of heart diseases, diabetes, poor nutrition — all of the social determinants of health are differentiated in some First Nation communities. The study that was done on high-risk behaviours of school-aged children confirms that rural, small community-based kids suffer disproportionately to urban kids.

Given that most of our communities are predominantly First Nation, it's an easy leap to make. The difficulty for us here is that we have to take the lead from the First Nation government on determination about what priorities it's going to pursue in respect to population health issues. To the extent that we can support that, we do support that. We support a resource at the hospital. We support a resource at the Council of Yukon First Nations and we, as I said, take our lead from them.

Ms. McLeod: Business plans, paragraphs 26 to 28 — in paragraph 28, the Auditor General says, "However, we found that the mandate, goals, and objectives in the key planning documents — strategic plan, department plan, and Main Estimates — are not consistent.… The Department is in the process of aligning the strategic plan to the branch and unit level as well as the individual employee plans."

So the question is this: What progress has the department made in aligning its strategic plan, the department plan and the main estimates?

Mr. Whitley: The goals and objectives in the strategic plan and the departmental plan are now consistent. That is one of the first things we addressed with the language of the documents. The main estimates now contain departmental overviews and program descriptions that contain the broad statements that define the general purpose of the department, while the program descriptions identify in general terms the clients we're serving and the services that were performed. Those are not meant to be compared with the goals and objectives in the other plans. If you wish, I have a copy of the 2013-14 departmental overview and program descriptions and instructional guidelines as an example. I can show you those if you wish.

Ms. Hanson: Thank you, Mr. Whitley, we will most likely want to take you up on that variety of reference materials you have cited this morning.

Ms. McLeod: What is the current status of the alignment of the strategic plan to the branch and the unit level, as well as individual employee plans?

Mr. Whitley: That work is ongoing. I can't sit here today and tell you that it's fully aligned. That is where we are going.

The introduction of the strategic planning process involves a change in culture in a department. People at the line level sometimes don't see the connection between the high-level objectives of the department and the work that they are doing immediately in front of them. I recall clearly that when I went out to one of the communities to provide a copy of the strategic plan to all of our colleagues, one of them said, "You could have saved the money on printing this. What do I need this for?" It shouldn't have surprised me, but work has to go into developing a culture of global thinking and thinking ahead, of thinking beyond the immediate file in front of you. That is difficult when people are busy, so we are working on that.

Ms. Hanson: Thank you, Mr. Whitley. I'll be asking this next serious of questions, so for the purposes of the *Hansard*, if they hear a female voice, it's me, and then there is most likely Mr. Whitley, unless Mr. Whitley changes to having somebody else respond.

Following on the issues that Ms. McLeod just identified, recommendation 43 said, "The Department of Health and Social Services should prepare a human resource plan." In its response, the department agreed, "As indicated in the report, the Department has drafted a framework for a human resource plan. When complete, the plan will address succession planning, mentorship, recruitment, and retention. Work is well underway and a draft plan is scheduled to be completed in the next six months for consideration by the deputy minister."

The department, in its response to this recommendation, says the draft human resource plan is scheduled to be completed in the next six months. The Auditor General's report, as we know, was released in February 2011, which means the draft plan should have been completed by the end of August 2011. My first question is this: Could you please describe the elements of the framework for human resource plan, and where are you in developing the human resource plan? Is it complete?

Mr. Whitley: I'm trying to find the shortest way to answer your question. The human resource plan is done. I have it in my hand, so it can be for your view later on today, if you wish. Again I want to go back to the organizational structure and the governance of the department because it flows through virtually everything that the auditors have identified.

The human resource plan was developed by the senior management team, so that's the SMC group. The plan identified three goals and each goal had a specific item. I won't go through everything, but I'll just tell you what those three goals were: to identify and address the HR issues and needs in the department — there were three points to ensure that that was accomplished; the second one was to ensure the right — when I say right, I mean the appropriate mix — quantity and the skills of human resources in place to deliver quality health and social services. Points, again, are identified under that to ensure that that target is met. Then the third one is to ensure a safe and healthy workplace. Again, there were points identified in that. That was fleshed out in this plan that I have in my hand. We have reorganized to maximize our service delivery and internal business practices are now all under review to ensure that they're consistent with the plan.

Ms. Hanson: Thank you, Mr. Whitley. So, that means that the plan is in place now?

Mr. Whitley: Yes.

Ms. Hanson: Does this human resource plan address succession planning, mentorship, recruitment and retention?

Mr. Whitley: Yes. That's under point number two, ensuring the right mix.

One of the strategies that are required is retention, recruitment and succession planning.

Ms. Hanson: Are details set out for that in terms of the how?

Mr. Whitley: There is a general direction in the plan. It now falls to the HR group to put flesh on the bones.

Ms. Hanson: Thank you, Mr. Whitley.

I will move on then to recommendation 4: "The Department of Health and Social Services should develop key health indicators and benchmarks for them as well as quantifiable health outcome targets. It should then compare benchmarks and targets with actual indicators and outcomes for Yukoners and major population sub-groups and analyze any gaps to determine what needs to be done to close the gaps. The Department should identify performance indicators, targets and measurement processes for its diabetes and alcohol and drug services programs."

In response, the department agreed. The department said it will work toward developing key health indicators and outcomes specific to Yukon, as well as setting reasonable targets and benchmarks where comparable data is available within the next 18 to 24 months. It has now been 20 months since the release of the Auditor General's report. Are the comparable data for key health indicators, outcomes, targets and benchmarks available?

Mr. Whitley: I have some notes here and I'll just touch on some of them briefly in terms of how we responded to this particular recommendation. One of the things we immediately started to do is to try to recruit — and we now have successfully recruited — a health and social services research analyst whose expertise will address the issues in the recommendation. What we're particularly interested in is the Yukon program-specific health indicators. Sometimes I think there's such a thing as too much information, but somewhere I've got those and I'll come back to that.

In addition, as part of our wellness strategy, we have developed an indicator framework document called *Kids Count*, and I have that document with me here. Its subtitle is, "An indicator framework." Just to quote briefly from the introduction to the report: "This report presents a set of indicators organized within a framework that will allow the Yukon government to track and report on how well Yukon's children and families are doing.

It looks beyond physical health outcomes and examines many of the factors, for which reliable measures exist that allow individuals to live healthy, successful and fulfilling lives."

I should say that it was developed through an extensive literature review and analysis and a comparison of what is being done in other jurisdictions as well.

The third point I would mention in response to your question, Madam Chair, is that the next health status report by the chief medical officer of health is forthcoming shortly, and it too will focus on children and youth health and wellness in Yukon, in keeping with this identified priority. Continuing care has collected data. It has set performance indicators, benchmarked and set targets for outcomes for a measure of population subgroup — that's our aging demographic. The Yukon home care program was the first jurisdiction in Canada and the continuing care facilities were a very early adopter of the national continuing care and home care reporting systems, which reported on these indicators of health.

We actually got national recognition for that. I could go on, but I think that you are getting the sense —

Ms. Hanson: The sense that I have, then, is that the department has developed some key indicators. How does the department plan to use this data? How is the data that is being generated used to inform decision-making?

Mr. Whitley: That is an excellent question, and I would say that it would be used to modify programming, abandon programming — if there is marginal return for the investment in a particular program we certainly wouldn't look to continue it — and redeploy that money where it might better be used, or to support requests to our own government or to the federal government for resource assistance.

Ms. Hanson: You said it would be used. Is it being used?

Mr. Whitley: Yes it is. It is being used —

Ms. Hanson: In that context?

Mr. Whitley: In our Management Board submissions and in our submissions to the federal government.

Ms. Hanson: There are a number of observations that the Auditor General made that sort of fit into a broader basket with respect to some of these key indicators and benchmarks.

I'll just go through them in setting up to the last the questions I have.

Paragraph 5 of the report says that, "Yukon's *Health Act* states that the 'primary objective of Yukon's health and social services policy is to protect, promote, and restore the well-being of residents of the Yukon in harmony with the physical, social, economic and cultural environments in which they live and to facilitate equitable access to quality health and social programs and services.'" The report goes on to say, in paragraph 47 that "the Department has not established" — and we have talked about this — "either key health indicators or targets for them." It also found that they had not established targets for health outcomes so that the department can't compare targets to actual health outcomes or to actual health indicator results.

In paragraph 48 they went on to say that, "Without establishing key health indicators and benchmarks for them, or target health outcomes for Yukon and key population groups, such as First Nations and Aboriginal people or communities outside of Whitehorse, the Department cannot assess whether it is making satisfactory progress in these areas, whether it has the right programs and services in place, and whether resources have been allocated properly."

The auditor's report went on in paragraph 51 with respect to performance measurement, and we have talked a little bit about this.

In particular, the focus in paragraph 51 was with respect to indicators or lack of indicators and outcomes or measurement processes in place for either the diabetes or the alcohol and drug services programs. As a result, the auditors found that the department can't monitor performance, assess the progress of programs, or report on their effectiveness. This means that the department cannot determine whether these programs and services are meeting the needs of Yukoners.

Finally, in paragraph 52 it says that because the *Substance Abuse Action Plan* "did not have targets, goals, performance measures or evaluation requirements… the effectiveness of the *Substance Abuse Action Plan* could not be assessed."

My question, Mr. Whitley, is this: How then does the department ensure it meets the primary objective of the Health and Social Services policy if it cannot evaluate the effectiveness of programs or determine if programs and services are meeting the needs of Yukoners?

Mr. Whitley: The first point I think I'll make with you is to the specific program that the auditors evaluated and that was the diabetes program. The diabetes program, as part of the chronic condition support program, now has performance and health outcome indicators for diabetes. The clinical practice guidelines and flow sheets used by the physicians who are enrolled in the chronic care collaborative measure the performance in the area of diabetes.

If I can jump ahead to another issue, because it's relevant — one of the things that we are going to be doing and have been working on for some time, is a key indicator report, or a state of the health of Yukoners for calendar years, the first one being the current calendar year we're in. Where we're having some difficulty is in determining which key indicators of health we'll look at. Now, there are many key indicators of health, as everyone knows. There is infant mortality, life expectancy, suicide rate, the obesity rate, issues having to do — and these are less capable of specific measurement — with psychological stress and mental illness, unmet dental and medical needs, childhood immunization, hospital access, and so on and so forth. That's on the — strictly speaking — health side.

On the social determinant side, there are many indicators, as well — the unemployment levels, the median income, the graduation rates in schools, physical activity, nutrition and so on and so forth — so it goes. So the capacity of our department to collect information along those indicators, let alone the information we do have at our disposal — such as the HIV rates, the rates of diabetes, the rates of particular kinds of cancers and so on — is quite limited.

So we need to focus on which of those indicators we're going to select. Having said that, as I mentioned earlier, we have a tiny population. It's one thing to compare the standards that

apply in downtown Toronto, whose cancer clinic sees more people in a day than our entire hospital system sees in a month — or several months, actually — but it's quite another thing to understand that our people involved in our diabetes program know every single patient by their first name and know, on an intimate basis, how they're doing and how they're progressing. Now, that's not the same as collecting the data, which has to be done. It's not the same as using that data to modify the program, approve it and so on.

That clearly has to be done, but there is no big-bang approach to taking the Auditor General's recommendations and, within a year, having it all tucked away. What we are trying to do is proceed responsibly, identifying those areas where we think we can make a big impact because, it has to be remembered, we agreed with the recommendations of the auditor. This isn't about quibbling with their recommendations; they're eminently sensible.

Ms. Hanson: Thank you Mr. Whitley, and I think your response does lead into my next question, because you have spoken about the capacity of the department and identified in general terms a number of key indicators of health and social determinants. What analysis has the department done to determine the scope of work or resources that will be required to actually establish these as key health indicators and targets for them and targets for health outcomes?

Mr. Whitley: There has been an enormous amount done on the social inclusions side as well as on the wellness side. We have deliberately taken significant resources and put them to those two strategies to look at precisely the kinds of things that you just asked about.

The result is, in respect of the focus that we're taking, which is on children and families, we have the *Kids Count* document, which is — I have it with me here — an extensive document that identifies most of the issues that you have raised, so that it informs the kinds of things that we're going to tackle — but there again, there's no big-bang solution to changing attitudes about kids' health. If it was tough to change attitudes about strategic planning where people can be actually told what to do, it's going to be very difficult to change the culture around wellness where there are so many factors that are well outside our control, like nutrition, like parental involvement, like the attendance in schools and all the other indicators that are in this document.

Ms. Hanson: Does the document you referred to speak to the scope of work or resources required to focus on these areas?

Mr. Whitley: No, it doesn't, but what will happen now is that we'll take portions — depending on the people who are doing the work on this — of this document that will fold then into our operational plan for the coming year. This is what we're going to do, this is how we're going to fund it, this is how we're going to know if we're successful.

Ms. Hanson: Thank you, Mr. Whitley.

My last question has two parts. Has the department, since the release of the Auditor General's report, developed measurement and outcome criteria for the diabetes and alcohol and drug programs? You mentioned that there has been, in terms of critical practice, guidelines for the chronic care with respect to physicians enrolled for diabetes. Is that a pilot project? The second part is more general with respect to measurement and outcome criteria for these two programs.

Mr. Whitley: I'm just speaking to the first part of your question, Madam Chair. The answer is no, it is not a pilot project. It is built into the program now and will remain.

With respect to the second part of your problem, I am just trying to find the study that addresses the drug and alcohol issue. The Drug and Alcohol Services branch have been aware, long before the auditors got to town, that the concerns that they raised we anticipated from the start.

We needed to know by the establishment of standards whether or not the work that we were doing had any kind of consequence at all. As someone who has been in the Yukon for a long time will appreciate, much of this was idiosyncratic. We know our patients. We know them intimately. There's a sense that — well, we know when we're doing well or not. But we recognize that there has to be a more formal implementation of standards in our drug and alcohol program.

So, to that extent, we approached the federal government and scoped out a program to do exactly that. That program is a three-year program. It's about $1.7 million for the entire program. The deliverables for that program will be an addiction services standards manual for treatment — and it's going to be based on best practices and so on — and an addiction services standard manual for detox. There will be data collection tools and methods for performance measurement and program evaluation — client checklists, survey tools and that kind of thing. There will be a baseline program evaluation for detox and treatment so that we can measure from that benchmark. Then, at the end of it, there will be a final project evaluation report.

Now, this has a number of consequences. First of all, I think it directly answers your question. Secondly, we're hoping for some knowledge transfer from that enormous expenditure of money into other programs that we do. Thirdly, it's going an enormous distance toward changing the culture that I talked about, in terms of people understanding the importance of this kind of an exercise.

Ms. Hanson: Thank you, Mr. Whitley. I'll now turn to my colleague, Mr. Hassard.

Mr. Hassard: Thank you, Madam Chair, and thank you all for being here today. I'll be referring to paragraphs 54 through 71.

The recommendation was that the Department of Health and Social Services should develop a comprehensive health information system that allows the department to collect and report on complete and accurate health data from all available sources. The department agreed. In the response, they said that they will commit to initiating a review within the next six months of all available health data, including information specific to diabetes and alcohol and drug-related problems to determine what information can be used currently. As of January 2011, the department hired an E-Health Director, whose spe-

cific role is to oversee the Yukon's electronic health record initiatives, as per the Canada Health Infoway mandate.

My first question is a two-part question. In its response, the department say that at the time the report was written, it lacked the resources to undertake a comprehensive health information reporting system. Have those resources been secured since then, and could the department provide an estimate as to the resources required to undertake such a reporting system?

Mr. Whitley: The short answer to your question is no. We have not secured those resources yet, but we have secured some of them, and in 2011 we hired an e-health director — I think you saw that in our preliminary report to the auditors, and his work has commenced by way of an overview for the department. What he is looking at is the enormous undertaking that is involved with a comprehensive health information system.

Our issues involving the availability of data and the larger issue, which I'm sure all of you are aware, is that we're not simply just talking about numbers on a sheet, but we're actually talking about human beings and the condition of their health. So the consequence is that health information is highly personal, highly confidential, and highly restrictive in the way that we can manage it, particularly when you consider our small size. If we identify one person who has HIV in one community — well, we simply don't do that because of the problems that would flow from that.

So we have made it a priority in our response to this recommendation to address the privacy issues first. We're moving forward with the development of health information and privacy legislation that will protect Yukoners' health data and ensure that, when it is used — and the most common use of this is for aggregate data, where we look at trends, where we identify population health issues, but again, with such small pockets of population — we have to take greater care than we would necessarily in, say, British Columbia.

Now that said, we have been working toward an electronic health record under the leadership of our e-health director, and they are finishing the high-level planning and assessment phase sometime before Christmas this year. This initiative includes the identification of functional and business requirements for Yukon e-health, which will be supported by conceptual technical architectures — that is the wording that I was given and I am a little bit in awe of it, but that's what they tell us they need to do. They want, we want, I want the working group to make recommendations regarding a governance and privacy and security framework. An intra-organizational team with representations from our department and the Hospital Corporation, information technology at the Government of Yukon, together with some external experts, have been working on this now for quite some time, and we expect something very shortly from them in the way of recommendations. Funding for all this has been provides through Canada Health Infoway. What they have told us is that the most important part of this whole exercise is the planning and assessment phase, the part that is actually going on right now.

I could go on at length on this question, just to detail how complex it is, our dependency on British Columbia because we are going to ultimately tie into their system so we can get away from the smallness of population issue.

Ms. Hanson: I think that is adequate. Thank you, Mr. Whitley.

Mr. Hassard: Thank you, Mr. Whitely, and actually, I think you have answered the next four questions as well with that, so you don't need to go on any greater length for me.

Moving on to paragraph 56, it says that "Yukon is one of four jurisdictions in Canada that do not require ICD codes to be filled in and submitted by physicians." Recommendation 70 states, "In collaboration with physicians, the Department of Health and Social Services should establish compulsory International Classification of Diseases coding", or ICD coding. The department agreed. I guess that leads to the question: Does the department have anything to report with regard to its review of the ICD coding requirements, and how far has the review progressed?

Mr. Whitley: That's part of moving the department into the 20th century. It's not that we don't have the information. We have the information that would be caught by ICD coding, but it requires a manual search. So it was necessary for us to move in that direction. To do that requires the cooperation of the physicians in town, which means somewhat more work for them. However, during the recent negotiations with the physicians, one aspect of that I can report is that they have agreed to do that. By September of 2013, all the reporting will be consistent with ICD coding.

Mr. Hassard: Has the department instituted measures to increase compliance, then, with the requirement to code billing by physicians?

Mr. Whitley: The compliance mechanism that we've all agreed on is that it will cost physicians after our drop-dead date of September 2013.

It will cost them if they don't comply with ICD. In other words, we'll have to do it, but we'll bill back the cost of that to the physicians, so we don't expect any problem there.

Mr. Hassard: Paragraph 57 says, "The Whitehorse General Hospital also has systems and processes in place to enter ICD codes for hospital admissions and does so for the purpose of reporting to the Canadian Institute for Health Information… However, the codes are not broadly or consistently used by either the Corporation or the Department for gathering and analyzing information about diseases or health conditions in Yukon. In addition, information, such as ICD codes from Watson Lake Hospital, is not reported to the Canadian Institute for Health Information."

Have Yukon Hospital Corporation and the department developed protocols or other means to ensure use and analysis of this information, and is the Watson Lake hospital part of this protocol?

Mr. Whitley: The short answer to that question is no, not yet, but we will. Our priority was to get our own house in order and that's largely on its way. The next step will be to be

developing protocols between us and the hospital, which is under a new CEO.

Ms. Hanson: I will now move to my colleague, Mr. Kent.

Mr. Kent: First of all, I would like to thank Mr. Whitley and his colleagues for appearing here today. Many of us know that Mr. Whitley is moving on to some new challenges. I would like to take the opportunity to thank him for his services as Deputy Minister of Health and Social Services over the past number of years. On a personal note, I have enjoyed working with you and your officials over the past year in my capacity as an MLA and Cabinet Minister and, prior to that, in my roles with the Yukon Hospital Foundation and Canadian Cancer Society. So thank you so much for all your work.

The line of questioning I have follows up on that of my colleague, Mr. Hassard — dealing with information management and data collection as it relates to the diabetes and drug- and alcohol-related health problems. So we'll start with paragraph 71. The recommendation there states that the data on diabetes and alcohol- and drug-related health problems should then be used to determine how the department's programs and services are affecting those individuals and if any changes to the programs should be considered. Is this now being done?

Mr. Whitley: With respect to the chronic conditions support program, of which the diabetes program is a part, we agree that we have no information system that systematically collects data in the community health centres. However, we do have physician visit data for people who reside in communities, and we do have physicians going to communities on a regular basis. So we are able to track some data from the diabetic population from that source.

What we don't have, and what we are working toward, is an electronic health record for people who visit health centres in the communities. This will be part of the e-health project once we get into the implementation phase. I have seen this in action in Sweden and Finland, and to me there doesn't seem to be any insurmountable obstacle to putting this in place, other than the cost of it and the addressing of privacy issues.

If we didn't have such a small jurisdiction here, we could go it on our own, but we are required to work with — in fact, our federal funding depends upon working with British Columbia.

Hon. Mr. Kent: So, in the department's response to that recommendation, obviously agreed and said that within the next fiscal year — which I'm assuming would have been 2011-12, based on the timing of this report — that the department would develop a formal reporting policy to ensure that regular program data reporting includes performance indicators common to all programs. Can you tell us if there has been progress made on that particular response?

Mr. Whitley: I think that in response to an earlier question, I had indicated that the diabetes program now does have those indicators and benchmarks in place. We are in the final stages of a review of the insured health services data stores, and awaiting a report which will make recommendations on how we can make that data, with the existing system that we have, more accessible to staff for analysis and reporting out of not only diabetes, but all comorbidities that we address in that program.

Hon. Mr. Kent: The final question with respect to this recommendation deals with the Department's plans to work with the Yukon Bureau of Statistics to develop trend analysis data that will better address priorities and funding pressures.

Can you inform us if there has been progress made on that particular part of the response?

Mr. Whitley: The first point of contact for us with the Bureau of Statistics had to do with our problems around extra jurisdictional patients that I referred to earlier as an issue for us in accounting. We wondered whether or not they could develop a projection model for us around some assessment of which numbers of patients might be out of the jurisdiction at any particular time. They have done some work on that, but since then the person who was working on it, who was the director, has left and that work has not been pursued. It hasn't been pursued for the reason that we found it more productive for us to develop closer ties with the administration of health services at the ministry in Victoria.

So we're getting more information from them as a result.

The second part of your question had to do with —

Hon. Mr. Kent: It was just the progress made with respect to working with the Bureau of Statistics in the development of trend analysis, as committed to in your report.

Mr. Whitley: I recall now, thank you. The Bureau of Statistics is basically in the position of saying to us, "We will do some analysis and trend projections for you, once you get us coherent data," and that's what we're in the process of doing.

Ms. Hanson: Thank you, Mr. Whitley. I'm just noticing, in light of the time, perhaps rather than getting into the series of other questions that my colleague has, perhaps we could recess for lunch and reconvene at 1:30 p.m., if that's okay with everybody. We'll reconvene at 1:30 and Mr. Kent will continue.

Thank you very much to you all. Enjoy your lunch.

Recess

Ms. Hanson: Perhaps then we'll get started since we're all here and hopefully had decent lunches.

We'll resume with Mr. Kent and the questions he had.

Hon. Mr. Kent: Before the lunch break we dealt with the questions with respect to the recommendation in paragraph 71. There are just a few other issues I would like to touch on with officials. Paragraph 55 of the report states that the Auditor General "found that the Department does not have a comprehensive health information system to collect and report complete and accurate health data. The Department has several systems that it uses for different purposes. We noted that the Department's systems aren't compatible with each other and the Department does not integrate this information."

Have measures been undertaken by the Department to make these data collection systems integrated and compatible?

Mr. Whitley: The short answer, sir, is that the area where we are focusing our attention right now is on insured health. The e-health project is going to be critical in terms of establishing a protocol with British Columbia that is compatible with their systems, so we're focusing there.

But there are other systems in the department that are wholly incompatible and will necessarily be the subject of fairly significant fusions of resources.

Hon. Mr. Kent: That last point feeds into my next question. Is there an estimate of what resources may be required to make this possible, whether it's financial or human resources?

Mr. Whitley: No, there isn't.

Hon. Mr. Kent: Now, on to paragraph 58 — again, we've touched on some of this stuff, so I apologize if you've already given the answer, but I'll just ask the questions again so we can get them on our record so when we compile the report, we will be able to move through the transcript relatively easily. Paragraph 58, of course, deals with implementing the electronic health records. It's noted there that it has been slow in the Yukon, as it has been in other Canadian jurisdictions, due to high costs, integration issues and, again — we spoke about this earlier — but ensuring confidentiality of individual health records. I think you mentioned before the break, as well, that there were no insurmountable obstacles other than resources, and you did visit Sweden and Finland, I think, to look at that.

The question is, Has the situation with regard to electronic health records, vis-à-vis the resources and that type of thing, improved in the Yukon in the last 20 months since the release of the Auditor General's report?

Mr. Whitley: The response to the question has really to do with recognizing the fact that all of our improvement, involvement and advancement in this area has been dependent upon federal funding, so we have to submit a plan to the federal government about what we're going to do with the money, how we're going to accomplish it and so on. Then they approve the expenditures as we go along.

I should say that when I met with the CEO of Canada Health Infoway, Mr. Richard Alvarez, just this summer, he once again told us that based on their experience elsewhere in Canada, you cannot underestimate how important it is to plan and move carefully. Other jurisdictions have pushed hard to develop the e-health records and have failed spectacularly — most spectacularly in Ontario, you may recall, a couple of years ago.

In terms of our funding, we are pretty much dependent on the federal government, which has been generous, I must say.

Hon. Mr. Kent: Moving on to paragraph 59 that deals with contracts with physicians who deliver services in communities without resident doctors. The department, of course, has those contracts in place and they specify the level of services to be provided and require physicians to report their activities to the department. However, it notes that, "The Department does not compile, analyze, or use this information to improve programs and services in the communities."

What has the department been doing with the information submitted by physicians on contract in communities?

Mr. Whitley: The recommendation here speaks to the reality of not having a formal systematic means by which data is gathered, as one might expect in a 21st century health care system. However, the department does require physicians to do what we call in the department "shadow bill" with respect to their activities in the communities, even though there may be a contract for the global supply of medical services.

Nonetheless, the shadow billing concept involves the physician billing the Yukon health care system of insurance, as if there was a fee-for-service claim going on. In that way, we're able to ascertain what kinds of activities are going on in a particular community. So all claims, including those submitted as shadow billings, are reviewed by officials in the insured health unit of the department to determine whether or not they are adhering to the rules, both in the contract and in terms of billing generally. Then the claims data is used in analyses, which are performed by the department, to look at things like prevalence of disease, to look at billing patterns by the particular physician, and to assist us with random physician audits we do from time to time to ensure that doctors are actually out there doing what they're supposed to be doing within the terms of the contract.

It's a requirement now in all physician contracts, and if they are not submitted — that is, if the shadow billings are not submitted in a timely way, then we would hold payment until such time as we do have them.

I could elaborate on that a bit, but that's kind of what's happening, so that it's not as if there's a vacuum in terms of data.

Hon. Mr. Kent: Thank you for that, Mr. Whitley. You did touch on some of the things about how the department is planning to use that information in the future on a go-forward basis. Maybe I'll move on to my next question that is specific to paragraph 62 and the non-collection of diabetes data on the communities because it has no systematic way of identifying the number of patients who require diabetes care within the communities. I guess the department does not collect that data on the communities. My question, with respect to that is this: Has the department now developed that method or that systematic way of identifying the number of patients within the communities that require diabetes care?

Mr. Whitley: The answer, in some respects, relates back to what I just said. While it's true that we don't have any information system that relates to individual communities, we do have physician visit data for people who are being treated in communities by physicians doing locums. When they go to the communities on a regular basis and treat people for diabetes or monitor their condition, we do have population health data from that source.

What we don't have is an electronic health record and that's where we need to move certainly in the next two to three years.

Hon. Mr. Kent: Just, then, to finish — and this is in respect to paragraph 64 — and I guess it's more of a comment.

You can choose to respond. I guess it relate to those electronic health records. In that paragraph, the Auditor General concluded that unless the department knows how many people have diabetes and how many are susceptible to it, it cannot determine if it is delivering the right programs and services to treat those with diabetes and those with a higher risk of getting the disease. From your previous couple of responses, you'll be able to get a better idea of how to allocate those resources once the e-health records and that type of system is in place, or is there anything you would add to what the Auditor General concluded in that paragraph?

Mr. Whitley: The practical, on-the-ground response is that people who have health conditions report them through their physician so that they can be treated; that's self-evident. Protecting the confidentiality of the patient, we nonetheless are able to pull out aggregate data from the billing information that we have. It's a hand-search; it's not something where we can enter into a computer program and pull out aggregate results, which we need to do.

Clearly, the Auditor General is right in that regard, but a balanced look at this will also concede that we do have the data. It is not as if the data isn't being collected. We do know how many diabetics there are in the territory. What we don't know is how many people are pre-diabetic; that is, at risk of developing full-blown diabetes over the course of time. That is something that an automated record will assist us in developing a strategy to address.

Mr. Elias: I am used to asking questions from the other side of the floor, so this is quite new to me.

First of all, thank you to everybody in the department for being here. I would also like to take this opportunity to thank my colleagues on the Public Accounts Committee for actually getting so far as to have a hearing. I thank everybody for being here.

With everyone's indulgence, I will begin with paragraph 65 in the same line of questioning as my colleague, Mr. Kent. It says that, "none of the Chronic Conditions Support Program or diabetes care activities are formally monitored or reported to the Department's senior management."

I realize we have touched on some of these topics, so my line of questioning will be from a different angle. Has the department changed this reporting structure, or does the department have a different plan for monitoring the chronic conditions support program or diabetes care activities?

Mr. Whitley: The chronic conditions support program now follows a flow-sheet in clinical practice guidelines for diabetes management, which is consistent with the national approach. The program manager monitors the physicians' compliance with the clinical guidelines for the management of those conditions and the results. This data is reported back to the manager of the chronic conditions support program, which in turn is then reported to the director of community nursing.

The department is about to begin work on performance measurement and health outcomes, and we'll start with this whole process — the data that has already been collected. We are now looking at a key indicators report, which is also a recommendation of the auditors, including aggregate data in this regard as well.

Mr. Elias: In paraphrasing paragraphs 66 and 67, it says the department does not regularly collect, compile or analyze data on the client base that uses its alcohol and drug services, and paragraph 67 says the alcohol and drug services program staff used to report to the department's senior management through the quarterly program report. However, the program report has not been prepared since December of 2009, and the department does not have a formal reporting policy.

So maybe I'll ask three questions in a row here. Why was the program report discontinued? Has the department reinstituted a means by which program staff can report to the department's senior management? Finally, if it has not, how does senior management provide direction to program staff?

Mr. Whitley: Let me start with the last question. The auditor made the observation that the monthly statistics report wasn't being done — and it wasn't being done for a reason. We had some serious problems with the way in which information was inputted into the system and, in fact, created a much distorted image of the clientele, the number of visits, the recidivism rate — if I can put it that way — and so on.

In all, the reports were virtually worthless, and it led to one of the reasons to approach the federal government for funding to develop the entire data collection analysis aspect of our evaluations- and standards-setting exercise that we were in the last year of doing. I touched on that in earlier responses.

Right now, both the treatment side and the detox side of our drug treatment program are currently using the tools and methods we have developed in the course of that federal project for data collection, and data collection now is being entered into an Excel program that is specifically designed to capture the performance measurements and program evaluation data. I've got a fair bit of notes here on it, but I'm not sure if that's enough for your purposes — or I can go on, if you like.

The short answer is there is a very good reason why we stopped those monthly reports. They were wholly unreliable. They were included in the House books for ministers. It was very worrisome that ministers had been relying on them up until them. Now, with the assistance of the federal government we are doing exactly what the auditors have told us we must do.

Mr. Elias: Moving on to the establishing, measuring and monitoring program section, with regard to paragraph 79, in the recommendation: "The Department of Health and Social Services should establish measurable objectives for its programs." Maybe I will just read the department's response into the record for those listening out there. This was agreed to by the department. "As an example, the Continuing Care Branch within the Department has completed the process of developing measureable objectives and indicators. The Branch has also completed and achieved certification (2009–2012) through Accreditation Canada for meeting national standards of excellence in quality care and service.

"Alcohol and Drug Services is in the process of establishing measurable objectives and evaluation criteria.

"The Department proposes to use the results of this work as a framework to assist in developing department-wide performance measurements and evaluation criteria. However, limited resources preclude the Department from committing to a time frame for department-wide implementation."

I do have a set of questions with regard to this section. In its response to the recommendation in paragraph 79, the department says, "… the Continuing Care Branch within the Department has completed the process of developing measureable objectives and indicators." Can the department summarize those objectives and indicators for the committee?

Mr. Whitley: The summary of the program objectives would include: a population focus, which is working with communities to anticipate and meet their needs; accessibility, which is providing timely and equitable services; safety, which is self-evident — keeping patients safe; work life, which is the balance that one would expect in keeping a healthy work environment; client-centered services, which is putting clients and families first; continuity of services, which is the experiencing of coordinated and seamless services; effectiveness, which is doing the right thing at the right time to achieve the best possible results; and efficiency, which is making the best use of resources.

Accreditation spells out within each of those objectives how they are accomplished.

Mr. Elias: The department also indicates that Alcohol and Drug Services was in the process of establishing measurable objectives and evaluation criteria when this report was released in February of 2011. Can you give us a report of what progress has been made on this initiative?

Mr. Whitley: The program produced an interim report last year, in which an update was provided to the federal government — to our funders — on what would have been accomplished thus far. I should say that there is regular contact with our funders to ensure we're moving in a direction that is consistent with what their expectations are for the funding agreement.

If I could just very quickly summarize what is in this document, which is the interim report: they identified and responded to three principal challenges. The first one had to do with staff time and interest type of tasks; demand for manager and staff time for the project and how that was to be handled; the issue of workloads for staff in one particular branch involving peer champions, providing binders and so on, information, multiple emails, et cetera — all of the work that goes into doing the assessments. Secondly, project management resources were considered and the aspects of the project that were underresourced were reviewed and the project was kept moving along. The third issue addressed was the software for data collection and the need for it to be understood by staff working with the consultants and so on.

Issues were identified early on in the progress of the program, and they were addressed in the course of doing the work. I have a whole document in front of me, and I can just tell you that the interim report addressed issues like implementation and adherence to the project plan, standards development performance evaluation component, implementation and the anticipated activities and outputs, standards development program evaluation implementation, adjustments and expected impacts of implementation. It also identified further challenges and how they might be resolved.

All that work has been done and there will be a final report very shortly, which will be available.

Mr. Elias: He answered my next question so I'll move on to the next one. Further in its response to this recommendation, the department states, "However, limited resources preclude the Department from committing to a time frame for department-wide implementation." Can you let the committee know how the department arrived at this conclusion?

Mr. Whitley: The conclusion that there would be a resource issue, in terms of evolving the lessons from the project itself — is that the question?

Mr. Elias: There seems to be some type of analysis that took place to come to that conclusion, so we were wondering how the department arrived at the conclusion.

Mr. Whitley: I apologize. I didn't understand the question.

The project for the alcohol and drug section was — and that is what I am assuming that you are talking about — a project that cost somewhere in the order of $1.7 million. As I indicated in an earlier response to one of the questions from the committee, it is our hope that there will be some knowledge transfer between the results of that exercise, the experience gained and the rest of the department. That is still our hope. There will be resources attached to that, which we will either have to find internal to our existing budgets or in the seeking of supplemental funding — either way. We know this because any of the exercises we do with respect to training. One of the areas we have focused on over the last couple of years, in particular, is finance training so that we change the culture of the department around responsibility for expenditures or, more particularly, overexpenditures.

We know that it costs money to train people, and even if we can do the training internal to our own organization, we still need to free people up for those training programs and fill in behind them. It costs money. So that is the reason for the response.

Mr. Elias: If I could go to paragraph 76, where it says ". . . the Chronic Conditions Support Program has prepared a vision, a mission, and goals, but not a mandate." Can we get an update on the progress that has been made in developing a mandate for this program?

Mr. Whitley: Thank you, Madam Chair, if I might have a moment? I apologize for the delay, Madam Chair.

The question was actually one I anticipated last night when I was going through my binder, and the note I wrote was that this seems like a simple question — or is it?

I forgot to follow up this morning, but having just followed up with my colleague, I can say that the mandate flows from the working group that involves the federal government because of the nature of the funding for this work. The funding right now comes through the THSSI program, which I spoke to

earlier. When we advance initiatives under the THSSI funding arrangements, it's necessary for us to have the concurrence of the federal government. It should also be noted that we work in concert with our sister territories, which are also involved in expending THSSI money. So there's a collaborative discussion that goes on around these kinds of issues. That's where the mandate is coming from.

Mr. Elias: Moving on to the *Evaluations need improvement* section and focusing on paragraph 84 and the associated recommendation, "The Government of Yukon should establish a program evaluation policy." I do recognize that this is government's response and I'll try to focus the question to the departmental level. The government's response basically agreed.

It says, "A government policy on the evaluation of funding programs is under development and is expected to be formally considered in the 2011-12 fiscal year. While the focus of the proposed policy is on government funding programs, the government contemplates departmental use of the policy principles and undertaking evaluations on a broader scale and on a regular basis as required." As it pertains to the departmental level, is the department now using these policy principles?

Mr. Whitley: Yes — I can say that in a number of instances we are doing exactly that, which is not to say that we're trying to get out ahead of the government-wide exercise. It's simply that it seems sensible to us to apply basic principles to program evaluations for the activities that we're carrying on right now. For example — and I won't go into detail unless you ask me to — we've developed a "home care for the homeless" project, which is a form of outreach — and I should back up a little bit.

When we talk about our initiatives and the selection of initiatives and the planning and discussion that goes into which priorities we will address, which has been the subject of earlier conversations, we look at our big priorities of social inclusion and wellness.

We know that there is a constituency that creates enormous stress on the emergency room of our hospital. We think that one way to alleviate that stress — and we've got several strategies aimed at that population — is to extend home care to people who basically live on the street. The question then becomes this: Is that a worthwhile expenditure of our funds? Is that working in terms of our overall objectives? That is the thinking that goes behind selecting that particular program. So home care for the homeless — we look at medical travel. We have done evaluations of that.

The two-track system at the hospital — and you may recall there is an experiment, where we tried to alleviate the pressure on the emergency room by developing a triage approach at the hospital, where minor matters went in one direction and more serious matters went on a different track at the hospital. We did an evaluation of that, and I can speak to that more if you like, but that is another example. The activity, generally speaking, in the territorial health access fund that the federal government provides us with — again, another evaluation done of that.

The LPN course at the Yukon College, which has been an invaluable source for providing us with LPN grads for our various programs — an evaluation has been done of that, in concert with Yukon College. Healthy families accreditation and so on — there are several here, and I could go into depth on each one of them, but the short answer to your question is yes, we are now routinely evaluating our programs.

Mr. Elias: I am sure we'll have supplementary questions later on as well. Moving on to paragraph 83, where it says, "In recognition of the lack of evaluations and performance measurements for the alcohol and drug services program, the Department sought funding from Health Canada to develop these. A three-year, $1.4 million agreement was signed in 2009, and the Department is now one year into the project. Under this agreement, the Department is to develop a program measurement and evaluation plan that includes indicators and targets for program measurement and evaluation by 31 March 2013." The associated question to this paragraph is: What progress can you report on the development of this program measurement and evaluation plan, and will it be completed by March 31, 2013?

Mr. Whitley: This was the program that I referred to earlier. It's actually now 1.7 rather than 1.4, because of the passage of time, I think. I'm just going to get it in my hand in a second — thank you very much. There were a couple of questions that you asked implicitly within the broad question. One of them was: Are the appropriate authorities and tools in place to support the decisions and take necessary actions? If I read that correctly into your question, the answers are that evidence performance measures are now used to measure implementation of new ADS standards. The new ADS standards are being implemented as they were planned in the original planning document. Evidence performance measurement data for new ADS standards is now used for quality improvement as the program proceeds along.

In terms of a further progress report, I am happy to report from the documents that I have that clients are now receiving after-care support from this program, which for the other two is not the case. Clients are now reporting reduction in substance abuse four to six months after treatment, which we did not know in prior instances. From our detox, we have information that clients who complete their withdrawal treatment participate in outpatient and in-patient treatment. We also have data that confirms that clients are reporting confidence in their ability to implement relapse prevention, which is a significant step forward. Outpatient clients now are reporting a clearer understanding of their treatment goals and their ability to work on them. There is a vast improvement in client-adaptive functioning, all of which seems to suggest that we are heading in the right direction.

Hon. Mr. Nixon: Before I begin, I just want to thank the officials from Health and Social Services for not only being here today to respond to our questions, but for the work that you do leading within your respective programs. So, thank you.

Looking at departmental monitoring and reporting, paragraph 89 states, "The Department of Health and Social Services

should institute a rigorous process for monitoring departmental and program costs."

The paragraph continues: "Subsequent to the audit, the Department has instituted a process for reviewing the cost of new and expanded programs."

You've indicated that the department is indeed working more closely with other jurisdictions to ensure that out-of-territory costs are accounted for in a timely manner for the hospital and physician claims. The department expected to have a structured process in place by the end of 2011-12.

In response to the recommendations that the department says, "Subsequent to the audit, the Department has instituted a process for reviewing the cost of new and expanded programs."

What new or expanded programs have been reviewed using this new process?

Mr. Whitley: In anticipation of what might possibly be asked, a list of programs that we've either accepted or rejected is not with me, but I can tell you that the programs to which I just made reference — such as the two-track approach at the hospital, the home care outreach project, the establishment of standards and benchmarks at the alcohol and drug program, the development of the Thomson Centre for its continuing-care/extended capacity, plus the prospect of palliative care provision — all of these programs now go through a structured review. My colleagues are handing me one after the other. Virtually everything that we do now undergoes financial impact prior to its consideration for the more substantive programming.

I should say as well that scarcely a day or a week goes by without someone coming to us for program enhancement or a subsidy of some kind, but that someone needs to do something in the realm of Health and Social Services. There isn't a request that's made to us that isn't worthy. There isn't a request that's made to us that doesn't have some compelling reason for it to be done. The problem for us then becomes, can we afford it? Is there a way for us to do this and does it fit with the overall government-stated agenda and platform commitments?

So we do that analysis in one respect, which is to say, does it fit with the government's agenda? Does it fit with our overarching strategic objectives? But the most rigorous aspect of the analysis is the financial analysis. I can detail that for you, if you like. A comprehensive list I can't give you, but I hope I've given you enough to illustrate the kinds of things that we look at.

Hon. Mr. Nixon: I guess my next question ties into that. Could perhaps give us an overview of the effect that this process has had on the department's ability to keep its spending within its authorized budget?

Mr. Whitley: I can do that quite easily. We balanced our budget last year.

Hon. Mr. Nixon: Thanks for the quick response.

In the report, the department says that overspending in the fiscal years of 2008-09 and 2009-10 was due to costs from other jurisdictions that the department did not budget for. That is paragraph 87. In its response to the recommendation in paragraph 89, the department "expects to have a structured process in place by the end of the 2011–12 fiscal year that will include provisions for ongoing communications with service providers in other jurisdictions to better forecast annual expenditures."

Can you tell us if this structure is currently in place and, if so, how well it is working for the department?

Mr. Whitley: In response to the question, I can say that the process is in place and, just in speaking briefly to my ADM of Corporate Affairs, who has been centrally involved with the discussions that I started about a year ago with the then Deputy Minister of Health in British Columbia, our financial administrative people now have a close working relationship with their financial administrative people, bearing in mind that the organization of the health care arrangements in British Columbia are obviously quite different from here.

They have regional health authorities who are responsible for the delivery of the acute care systems that we access and, within the context of those arrangements, the billing then goes back to Victoria and, when Victoria processes the bills, they send us ours. I should also say that we depend hugely on British Columbia, to a lesser extent on Alberta. When I say depend on them, I mean in a sense of their good graces.

So there's a fine balance to draw between insisting that we get our billings on a regular basis so that we can process them properly and leaving things just as they are within the funding agreement that I talked about earlier on. Right now we have been able to build a relationship to the point where all of our expenses are received well into the following fiscal year, within the timeline they're allowed but sometimes still not with enough time for us to book the amounts.

On the one hand, we do have a good working relationship. It worked very well last year, and we were able to book all of our costs — or, book a reasonable amount of money to anticipate the costs that might come in after the end of the close of the fiscal year. The second part to your question just escapes me. If I have missed something —

Hon. Mr. Nixon: We were just wondering how well the system is working.

Mr. Whitley: So far, it's working very well because, as I said, we balanced our books last year, came in on target and for the previous two years that wasn't the case. I think we have made our case to British Columbia that there is some urgency for us to attend to this.

Hon. Mr. Nixon: Paragraph 86 cites the overspending amounts for the 2008-09 and 2009-10 fiscal years. Perhaps you can tell us what the overspending amounts were for the 2010-11 and 2011-12 fiscal years and what factors are driving these amounts.

Mr. Whitley: In both years, I'm advised that all the amounts related to extra-jurisdictional hospital claims. Now, the actual amounts I'll have to get for you because I don't have the books for those years. We don't have a top-of-mind number for you, but we can get them for you, if you like.

Hon. Mr. Nixon: As mentioned, paragraph 87 says, and I quote, "According to the Department, the overspent amount in both years was due to costs from other jurisdictions that the Department did not budget for," and you have alluded

to that. Can you describe in further detail the nature of these costs from other jurisdictions?

Mr. Whitley: These costs would be for hospital costs and delivery of primary, tertiary and acute care in hospitals outside the territory, and they would be based on the medical recommendations that were made in the jurisdictions themselves. There would often be consultation with the family physician here in Yukon, but not always.

Hon. Mr. Nixon: Looking at paragraph 88, it indicates that, "The Department has obtained federal funding through the two-year (2011–2012) extension of the Territorial Health System Sustainability Initiative to consolidate the progress made in reducing the reliance on outside health care systems and medical travel."

What can you report to us with regard to consolidating the progress made in reducing the reliance on outside health care systems and medical travel?

Mr. Whitley: This issue is one that concerns all three northern territories, particularly as you go east from Yukon. Curbing medical travel has proved to be a nettlesome issue for us because medical travel isn't an administrative decision, it's a medical decision. The idea that a bureaucrat can overrule a medical recommendation to take somebody out of the territory for treatment is anathema. No bureaucrat would recommend it and no politician would support it, I shouldn't think.

That being said, I take the view that in some respects medical travel is one way in which we keep our overall health care costs down. If you look at the percentage of expenditures across the country — and you probably can't see this graph from the across the way, but I can tell you that as a percentage of government expenditures, the Yukon's overall costs are static. The overall costs for government spending are going up, no doubt about that — our budget now is well over a billion dollars. But if you eliminate the general costs of things overall, starting 10 years ago our costs were at 30 percent of government spending. In 2012 our costs are at 30 percent of government spending and the line, as you can see, is pretty much flat all the way across. I should say in relative terms that if you were to look at another graph as a reflection of national spending — and again you can't see it from here, but the graph shows that as a percentage of government spending — you get a high in Ontario of 45.7 percent. Nearly half of everything they spend is on health care. The Yukon is at 18 percent.

That's just health care. For us to spend 30 percent of our government spending totals, it includes social services as well as health care.

One of the reasons for that is medical travel. We don't have big acute-care hospitals that can manage heart transplants and we don't have medical schools. We don't have the kind of expensive arrangements that the other provinces have to fund. So while it's true our medical travel costs are expensive and there's a strong push from the federal government to curb it, nevertheless it has to be borne in mind that the other side of the equation is that it keeps our overall cost down and has been doing very well at that for the last 10 years.

Now, what have we done with respect to trying to manage these things? We have changed the eligibility for the subsidy from the fourth day of travel to the second day, which actually increases our costs, and we have increased the per diem rate to $75 a day, which is an *ex gratia* payment and not necessarily something that should be made. It is not keyed to income, but nevertheless it is given to each Yukon citizen who has to travel to help offset costs.

We get a large number of complaints about this. People want to have all of their costs met — that is for another day to discuss. The reason I bring it up here is that we have now decided or determined that a fair and appropriate policy to manage costs would be to fix the amount that is given to any person travelling outside for medical attention to the amount of the lowest cost round-trip airfare available in any given month. What used to happen is that people would key their critical acute-care needs around holidays, drive out and bill us for mileage and per diems and hotels and all of that, and it used to amount to a pretty penny. Because of the pressures on the travel funds, we have limited that as one step in managing the costs.

Another aspect of it is negotiating overall costs with the service provider, which right now is Alkan Air. But there again we were hit in the last two years with — as you all know — extraordinary fuel cost increases. That worked to sort of offset any savings that we were able to accomplish. Another thing that happened that's important for this committee to understand is that the closure of the municipal airport at Edmonton had an impact on us. Without going into any detail, we had to divert more of our patients down to Vancouver.

We have made some steps toward managing the costs, but it seems like every step we take forward on managing costs, we're met with other cost impacts — again bearing in mind that overall it pays the Yukon to manage a sensibly run medical travel program.

Hon. Mr. Nixon: I'm looking at the response in paragraph 99 and I'm pleased to see that the department reports on its activities currently as part of the budget reporting process. It also indicates that the department will work with program managers to review and enhance reporting on performance indicators that can be used for program evaluations. Having said that, I'm wondering — in its response to the Auditor General's recommendation in paragraph 99, the department said it would release an annual report for the 2010-11 fiscal year and that report would be released by spring of 2012. Was this report produced and released?

Mr. Whitley: No, it was not. There are a couple of reasons for that. I know you can't see it from where you're sitting but I'm holding in my hand a mock-up of an annual report. This will be a key indicators report that will come out for the current calendar year. There has been some discussion around this report, what it should contain, what it shouldn't contain, and how we can maintain certain confidentialities around population and health. For example, we don't want to identify one person who has an HIV infection in one small community — that sort of thing. So when we report HIV rates,

we have to be careful about that. In our eagerness to comply with the Auditor General's recommendation, I think we set a timeline for us that was not realistic.

We have done a considerable amount of work on the report. We've got a mock-up of it here to show the committee. We are thinking that it will be a report in 2013 for 2012. People understand calendar years better than they do fiscal years, so that means an adjustment of our data for that. We're also in the throes of trying to decide what it should contain, in terms of the information that we're able to extract from the systems that we do have. We can extract certain kinds of data, but we'd also like to go further in the report and talk about trends — not just nationally, but in the Yukon, because we think that's one of the best ways to educate the Yukon public in terms of the health risks that are becoming self-evident in the population.

Hon. Mr. Nixon: I can truly appreciate the amount of work that has gone into that report and look forward to seeing it when it comes out.

In its response, the department also says, "Current and prior year actual and budget variances and trend analysis will also be included in future budget documents in accordance with Financial Administration Manual requirements."

I guess it goes right into a question here: Was that information included in the budget documents for the *First Appropriation Act, 2012-13* and, if not, will it be included in the information accompanying the main estimates for 2013-14?

Mr. Whitley: Yes.

Hon. Mr. Nixon: In its response, the department also says the department will work with the program manager to review and enhance the reporting on performance indicators that can be used for program evaluations. Is that being done?

Mr. Whitley: The comptroller of the department assures me that's all being done, and I can tell you from the numerous meetings that we've had around the budget and around explaining the variances to our colleagues, I know for a fact that it's being done.

Hon. Mr. Nixon: These will be my final comments for a question for this afternoon. Looking at paragraph 97, it indicates that "the Department did not submit data to the National Prescription Drug Utilization Information System Database at all because data did not meet specifications. In addition, it did not submit data to the National Physician Database for the 2006–07, 2007–08, or 2008–09 fiscal years."

Can you tell us: Does the department now, or does it plan to, submit data to the National Prescription Drug Utilization Information System database and/or the National Physician Database on an annual basis?

Mr. Whitley: The short answer is no. We were approached by CIHI, the Canadian Institute of Health Information, to submit data to the national databank before we went to our new system. At that time, because we didn't collect the information as the data elements they required for inputting consistent with the national system, we said that we would consider providing that information once we were established in the new system. However, the administration for the new system has been more time consuming than the department expected, and the result is that we are trying to find an additional FTE for this work in 2013-14.

If it is approved, we can then proceed with data submission to CIHI's national system.

Ms. Hanson: That brings us to conclusion of the questions that the committee had prepared in advance. At the outset of the hearing this morning, we talked about the opportunity for committee members to ask follow-up questions, and I would ask my colleagues if they do have any.

Before that, I just wanted to confirm something with Mr. Whitley. At several points during our deliberations today you made reference to a number of reports or documents and you have indicated that you would provide those to the committee. I would appreciate very much if you would forward those to the committee. That would be great.

Mr. Whitley: I believe one of our colleagues has been noting that. We will provide those documents certainly to you by tomorrow, I would expect.

Ms. Hanson: Thank you.

Ms. Whitley: If I may, with your indulgence, there is one small correction I would like to make for the record. In relation to recommendation 36, there is a reference that I may not have understood correctly, or may have misspoken. I think I left the impression that the completion of the wellness plan would be 2013, and in fact it is 2014. We have a two-year time frame within which various products will be delivered and, subject to the direction of the minister, released to the public. I wanted to correct that misimpression, if that was indeed the case.

Ms. Hanson: Thank you, Mr. Whitley. I would then turn to my colleagues here on the Public Accounts Committee and ask if any of them have follow-up questions.

Ms. Stick: I have one question. We heard a lot today with regard to communication with stakeholders and the importance of data gathering and information systems. I might be out in left field on this one, but what I'm curious about is — because we do have a parallel system with the federal government with First Nation health — is there communication between your department and that branch of the federal government in terms of their statistics and the information they gather on patients who receive services through them?

Mr. Whitley: The short answer to that question is yes, there is communication between the federal Department of Health and the territorial Department of Health and Social Services. I'm going to turn to my colleague from insured health to ask about statistics sharing.

Ms. Wright: I meet on a regular basis with the regional director general from Health Canada, and her colleagues as well are in touch with our directors in our areas. When we have questions about their medical travel programs or their drug programs, drug utilization, that kind of thing, we are able to ask them for statistics, but it is aggregate data. We aren't ever able to get patient-level data so that we could merge their data with our data and get a fuller picture. That's obviously a problem, but it has to do with protection of health information

and privacy legislation that prevents us from doing that. We do get statistics from them when we request them.

Ms. Stick: A follow up to that would be: Is there continued discussion about being able to get better information? I realize that the department is working on privacy concerns, but are those negotiations happening?

Ms. Wright: There are no negotiations happening per se, but the vision for the electronic health record work that Canada Health Infoway is "one electronic health record for every resident of the country that is as complete as possible", which would include health data from a variety of different sources.

So if we look ahead to that, that is the time and place where we'll see that information coming together. But again, because of the privacy concerns and different legislation that we have, it's not possible right now. We aren't in negotiations specifically around those data.

Mr. Elias: I have a question similar to my colleague about paragraph 24 and the strategic planning exercise. We all know that when it comes to health delivery in the territory, it basically looks like a spider web. There are a lot of different roles and responsibilities throughout the territory, whether it be self-governing First Nations and their goals and priorities, or non-government organizations like the Arctic Health Research Network — and it goes on and on, like for that matter the Council of Yukon First Nations' non-insured health benefits with the federal government — under this communication recommendation from the Auditor General.

I deal with this on a regular basis with regard to the delivery of access to health care and basically what category citizens fall into. They're frustrated with the communication processes or where they go or how they access certain types of social or health care programs.

I'm now going to your annual report that is soon to be finalized. To me, this paragraph needs a lot of work in our territory. I was wondering if there's a process that you're endeavouring to delineate as best as possible with respect to all of the programs that currently exist in the territory, right from the non-governmental organizations to different orders of government that are here in the territory and how that affects the citizens of the territory and if that could be communicated in some way in your annual report.

Mr. Whitley: Actually, that's an excellent idea. As we look toward finalizing our report, it may well be that we should put in a few pages about navigating the health care system, whether you're a First Nation government citizen or Yukon government citizen. It's confusing.

One of the reasons that we have a cancer navigator, for example, is that people who are suffering the stress of that particular disease often need help in navigating their way through a very highly complex spider web, as you put it. We will take that idea and follow it up.

Ms. Hanson: I have one or two questions, if I may. I would like to go back, for clarification to when we were speaking to the second recommendation which, within that, was the response that the department had on the completion of the *Yukon Social Inclusion and Poverty Reduction Strategy*. I was unclear — at least my notes to myself were unclear and perhaps you can help me clarify it quickly. The response from the department was that the *Yukon Social Inclusion and Poverty Reduction Strategy* was scheduled to be completed in the summer of 2011. My note to myself indicated that there was a response that indicated a social inclusion and poverty reduction framework had been completed. Is there an intention to complete a strategy and would that strategy be dealing with addressing the Auditor General's recommendations in terms of how that strategy will address the issue of timelines of health priorities and resources for dealing with the issues of social inclusion and poverty reduction?

Mr. Whitley: There are two parts to the question: one is the apparent completion date, which is long gone.

Ms. Hanson: My note was that there had been a completion of a framework, and I was wondering if there was an intention to complete the strategy — maybe I misheard. That's just what I was trying to clarify.

Mr. Whitley: The strategy will be going forward for government approval imminently, so I'm expecting that within the next month or so we'll have a strategy. The strategy is done; the consultations are completed; the advisory committee has reviewed everything. I think that very soon — I can't speak to what happens internally to government, but you might possibly know as well as anyone — we will have a strategy in the public view very shortly.

Ms. Hanson: Thank you Mr. Whitley. The follow-up is then, do you anticipate, given that it's not public yet, but given there has been extensive consultation, does that strategy address the Auditor General's recommendations that the department should rank its priorities? Will it have ranking, timelines and targets, and identify resources that are required to implement the strategy?

Mr. Whitley: Well, since the government hasn't actually approved it yet — and they may very well send it back to us to say just that — we don't think this priority needs the kind of attention that priority should get. As you know, government has the absolute right to fit recommended objectives and priorities within their own political requirements. I find it difficult to answer that question.

Ms. Hanson: I appreciate that, Mr. Whitley. I was trying to put that around it.

Mr. Whitley: And I understand where you're question is coming from, Madam Chair. There will be, certainly, regardless of what the priorities are, an element of that in it. That much I can say.

Ms. Hanson: I appreciate that, Mr. Whitley. Thank you. The other follow-up question I had was with respect to a question asked about the situation in regard to electronic health records in the Yukon and whether or not there had been an improvement in the 20 months since the release of the Auditor General's report.

Beyond the provision and the use of federal dollars to work on health records, is that the only sort of focus that's hap-

pened on electronic health — the expenditure of federal money?

Mr. Whitley: I have to say, Madam Chair, that the e-health project is probably one of the things that I have to deal with that is almost beyond my capacity to understand. I know now what a lawyer sounds like to a layman when we talk in arcane language. When the privacy people or IT people come in and talk to me, I sometimes want to say, "Give it to me plain."

I could tell you from the briefings that I've had that a tremendous amount of work has been done both on the legal analysis side in terms of the meshing of our privacy arrangements with the B.C. privacy arrangements.

I know there have been issues around governance that have been addressed, and there are working papers that are available. All of this has been vetted by Infoway. They seem to be satisfied with what we've done. They think we should be moving faster. We say we're doing the Billy Goat Gruff thing. We're small and we can't move any faster than we are. Beyond those generalities, I can't say today how much value we've received for that money, but I can get you some sort of a summary that will explain that for you better than I can.

Ms. Hanson: I appreciate that, Mr. Whitley. Thank you. My next, and probably second-last, follow-up question was with respect to the line of questioning that was around paragraph 59, which had to do with the whole issue of the Auditor General's observation that the department wasn't analyzing physician reports with the objective of improving programs and services. I just want to clarify something, because your response spoke to a certain degree about a focus on the adherence to the requirement to report.

I guess the focus of the question, where I was hoping you might take that was the use that the department would make of the information that is provided as a result of these physicians adhering to the requirement to provide the data. What use does the department make of that in terms of analyzing and then informing the decisions made around health care and health care delivery in the communities in particular?

Mr. Whitley: I apologize. I had the information in front of me and I don't know why I did not provide it all at once when I responded to the question initially. There are two aspects to how we utilize the data from physician claims. The first one is — and actually there are three if you take into account and are adhering to the terms of the contract question. We can look at physician claims data, and this is through the shadow billing that I have talked about, and determine what the reason for the visit of the patient is, along with the diagnostic information that we get from the physician. We can make some inferences about the nature of the disease in a particular community and the prevalence of that disease.

We do that now for diabetes, and even though only half the claims right now are ICD coded, we still have this physician data that will enable us to link with some kind of accuracy what the nature of the prevalence of the disease is in Yukon and in particular communities.

A practical example of that would be the possibility that we are going to recommend to our minister that we do a colon cancer survey in the territory. We need to look at data to make sure that's something worth spending money on. We think for a variety of reasons that it probably is, but it's much better if it's evidence-based when we take it forward.

The other aspect of analyzing the data is that we can look at work patterns. We can look at a physician's pattern of practice from the claims data and see how they compare to their peers. This is an issue that is national in nature. In the stewardship of the health care system, we are all trying to manage costs. One of the ways in which costs are managed or strategies evolving across the country is through clinical practice guidelines. There's a reasonable expectation that physicians will adhere to established clinical practice guidelines, which are taken from evidence-based research, and all the rest of it.

However, there is also, on the flip side of it, the autonomy of physicians and the degree to which they are free to order tests, to send people out for analysis, to insist on frequent visits and so on — all means by which a good analysis can be made of the whole patient picture, but all means by which the fee generation could go through the ceiling. That's a very tough call for a bureaucrat to make. But if we consistently see a physician whose practices seem so far outside the norm, then the data that we use from the billing practices is something that will illuminate that for us pretty carefully — and it has happened. It has happened, and we have addressed that through our own internal processes. That's one side of it. The other side of it is that we can tell if a physician isn't paying enough attention to their patients by looking at what comparable patients with comparable complexities have. I hope that —

Ms. Hanson: Thank you, Mr. Whitley, and that certainly does speak to the importance of — as you referenced, and the Auditor General did as well — having that data and the ICD coding.

You made reference just now as we were talking about the importance of the diabetes reporting program and the fact that even with — and I just wanted to clarify that, because I had made a note about this. I was trying to understand if, when you were talking about the diabetes reporting process, all doctors or just some doctors are involved in some collaborative project or collaborative practice that I don't know about are doing this reporting? Because, as you mentioned, we currently understand that roughly 51 percent of billing has the ICD coding. So is it different from diabetes? Do all doctors report diabetes now, or just some who are involved in some project?

Mr. Whitley: No. Regardless of whether the billing is coded traditionally by hand, electronically, or through the ICD coding mechanism, we still know which doctors see which patients for which condition. We know that. When we aggregate that data, we draw our inferences and our analyses from that. So it's not as if it's an optional thing for a doctor.

Ms. Hanson: So just for clarification — in simple terms, how does the department know what a doctor is seeing a patient for if there's no coding?

Ms. Wright: We will talk a little about the chronic disease collaborative and how that works. Initially, it was a diabetes collaborative and it was set up just to specifically deal with diabetes. It has expanded over the last few years to include a number of other conditions that would be considered comorbidities of diabetes, but I will just talk about diabetes. We will get you some more precise figures, but I believe somewhere between 80 and 90 percent of physicians who work in the Yukon are part of the collaborative for the chronic disease. As part of that collaborative, they agree to use the flow sheets and follow the processes that BC uses in their diabetes collaborative to follow their patients so that, in that way, the diabetic patients are counted and recognized so we know about them through that system.

It is true that only half of the physician claims that come in are ICD coded, but there are ways to code the data by writing computer programs. The physician on a claim typically writes a three- or four-word diagnosis for every patient they see. You can take that hand-written diagnosis and infer an ICD code into the claim data.

I don't want to get too technical, but there are ways to automate the coding of the claims to provide a better count of diabetics. So that, compared to the numbers of people on the rosters of the physicians who signed up for the collaborative, gives us a very good indicator of the numbers of diabetics. Does that help you?

Ms. Hanson: So the 80 to 90 percent of doctors who are involved in this collaborative, does this include contract doctors, or doctors who come in and out of the territory? Are they part of this 80 to 90 percent?

Ms. Wright: No, these would be resident physicians. We also have the community health centres using these processes.

Ms. Hanson: Thank you Ms. Wright. That's really all the follow-up questions I had. Did any other colleagues on the committee have any follow-up questions?

On that note, then, I think what I would like to do is suggest that we adjourn. Before I adjourn this hearing I would like to make a few remarks on behalf of the Standing Committee on Public Accounts. First of all, I would like to thank all the witnesses who have appeared before the Public Accounts Committee today. Whether you had the opportunity to speak or not, you have obviously put a lot of thought and effort into the issues that were the subject of the hearing today.

I would also like to thank the officials from the Office of the Auditor General and the committee Clerk, in particular, for his help on this.

The purpose of the Public Accounts Committee is to help ensure accountability for the use of public funds. I do think that the committee made progress in accomplishing that task today. The committee's report on these hearings will be tabled in the Legislative Assembly, and we invite those who appeared before the committee and other Yukoners to read the report and communicate to the committee their reaction to it. If you don't think we got it right, please let us know.

I would also like to add that today's hearing does not necessarily signal the end of the committee's consideration of the issues raised in the Auditor General's report. The committee may follow up with the department on the implementation of the commitments made in response to the recommendations of the Auditor General and of the committee itself. This could include a follow-up public hearing at some point in the future. With that being said, though, I'd like to again thank all those who participated in and helped organize this hearing. I now declare this hearing adjourned.

The committee adjourned at 2:55 p.m.