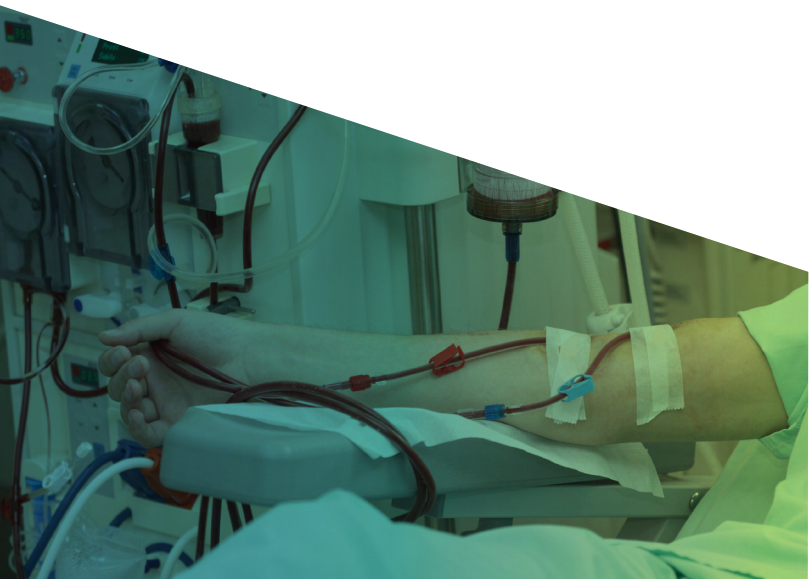
Auditor General
MANITOBA

Report to the Legislative Assembly

Management of Dialysis Services

Independent Assurance Report

WEBSITE VERSION



January 2026

WEBSITE VERSION

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Auditor General
MANITOBA

January 2026

Honourable Tom Lindsey
Speaker of the Legislative Assembly
Room 244, Legislative Building
450 Broadway
Winnipeg, Manitoba R3C 0V8

Dear Honourable Speaker:

It is an honour to submit my report, titled *Management of Dialysis Services*, to be laid before Members of the Legislative Assembly in accordance with the provisions of Section 28 of *The Auditor General Act*.

Respectfully submitted,

Original Signed by:
Tyson Shtykalo

Tyson Shtykalo, FCPA, FCA
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Auditor General's comments

Manitoba's health-care system is large, complex, and expensive, involving multiple organizations and stakeholders, including the Department of Health, Seniors and Long-Term Care, Shared Health, and other service delivery organizations.

Last year, the Province of Manitoba spent over $9 billion on health services, which underscores the importance of these services being planned, funded, and delivered in a clear, efficient, and coordinated way. This audit looked specifically at whether dialysis services—a critical and growing need for many Manitobans—are being managed efficiently.

We found that the Province does not have a clear strategy for dialysis services. There's no operational plan that connects what the system is trying to achieve with how it's going to get there. Roles and responsibilities are unclear, which leads to uncertainty and can contribute to inefficiencies. And the funding model is not tied to outcomes or cost analysis—which doesn't encourage smarter use of resources.

So what does this mean?

It means that even though dialysis is a life-sustaining service, the Province does not know if it is achieving the best results for patients and providing the best value for taxpayers.

More importantly, the problems we identified—lack of strategy, unclear roles, and funding that doesn't drive efficiency—are not unique to dialysis. MNP and Deloitte recently reviewed the governance, budgeting and fiscal management practices at Shared Health and other Health Service Delivery Organizations. Their reviews highlighted systemic weaknesses that threaten financial sustainability and service delivery.

This report includes six recommendations that will help the Department and Shared Health manage dialysis services, and health services in general, more efficiently.

I would like to thank the management and staff of the regional health authorities, Shared Health and the Department for their cooperation and assistance throughout this audit, and I extend my appreciation to my audit team for their efforts in completing this important work.

Original Signed by:
Tyson Shtykalo

Tyson Shtykalo, FCPA, FCA
Auditor General

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Report highlights

Why we did this audit

- Manitoba had the highest rate of end-stage kidney disease in Canada from 2013 to 2021, and the rate is still rising.
- Dialysis is the main treatment when a kidney transplant isn't an option.
- We wanted to determine whether the Department of Health, Seniors and Long-Term Care (the Department) and Shared Health are managing dialysis services efficiently.

Conclusion

Dialysis services are not managed in a manner that promotes efficiency.

Our report includes **6 RECOMMENDATIONS**.

What we found

Strategic direction

There is no operational planning for dialysis services

- Operational planning is needed to turn strategic goals into actions.
- The clinical and preventive services plan provides strategic direction for health services.
- There is no current operational plan aligning dialysis services to the strategic direction for health care.
- Shared Health is not fulfilling its legal requirement to monitor and evaluate health services.
- There is no step in the strategic planning process to look for efficiencies.

Defined responsibilities

Responsibilities for dialysis services are not clearly defined

- Legislation and agreements clearly define organizational responsibilities for health services, but not at the dialysis services program level.
- Shared Health has not defined operational responsibilities for dialysis services leading to uncertainty in the system.
- Accountability processes for non-performance are defined.

Funding process

The funding process does not promote efficient delivery of dialysis services

- Annual funding for health services is not based on strategic expectations.
- Dialysis treatment costs are not analyzed to inform funding decisions or assess efficiency.

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Background

Dialysis is a medical procedure that filters the blood to remove toxins, waste products, and excess fluids when chronic kidney disease has advanced to the point where the **kidneys** can no longer perform these functions.

Chronic kidney disease has five stages with the final stage being referred to as end-stage kidney disease (the disease). At this point, the kidneys no longer function, or the function is severely limited.

Chronic kidney disease is caused by kidney damage, often due to prolonged high blood pressure or high blood sugar, and sometimes long-term use of certain medicines.

In 2021, 38.9% of end-stage kidney disease in Manitoba was attributable to diabetes, which was the highest diabetes primary diagnosis rate per million population across Canada.

Kidneys are organs which:

- Help balance and regulate fluid in the body and create hormones that affect blood pressure.
- Remove waste from the blood.
- Get rid of extra fluid in the body.
- Help balance important minerals, including regulating the body's level of sodium, potassium, and calcium.
- Produce a hormone which can trigger bone marrow to make red blood cells that help deliver oxygen to the body.

While early detection and preventive measures can delay or prevent progression to kidney failure, the symptoms of chronic kidney disease may not appear until most of the kidney function has been lost. Because of this, many cases of kidney disease are identified only when other medical complications related to the disease occur and the individual requires medical attention. At this point, the primary treatment is dialysis.

Individuals with the disease require either a kidney transplant or ongoing dialysis to keep them alive. Although a kidney transplant is much more beneficial to the patient's quality of life, and it is a more cost-effective treatment option, many individuals with the disease cannot be a recipient due to their health situation. There are also a limited number of donor kidneys. As a result, dialysis is the primary treatment for the disease.

There are two types of dialysis treatments available:

- Hemodialysis is when blood is cleaned outside of the body using a machine and artificial kidney filter.
- Peritoneal dialysis is when the peritoneal cavity membrane inside the belly is used as a natural filter, cleaning the blood inside the body. It is a gentler form of dialysis that lets the kidneys hold onto their remaining function longer.

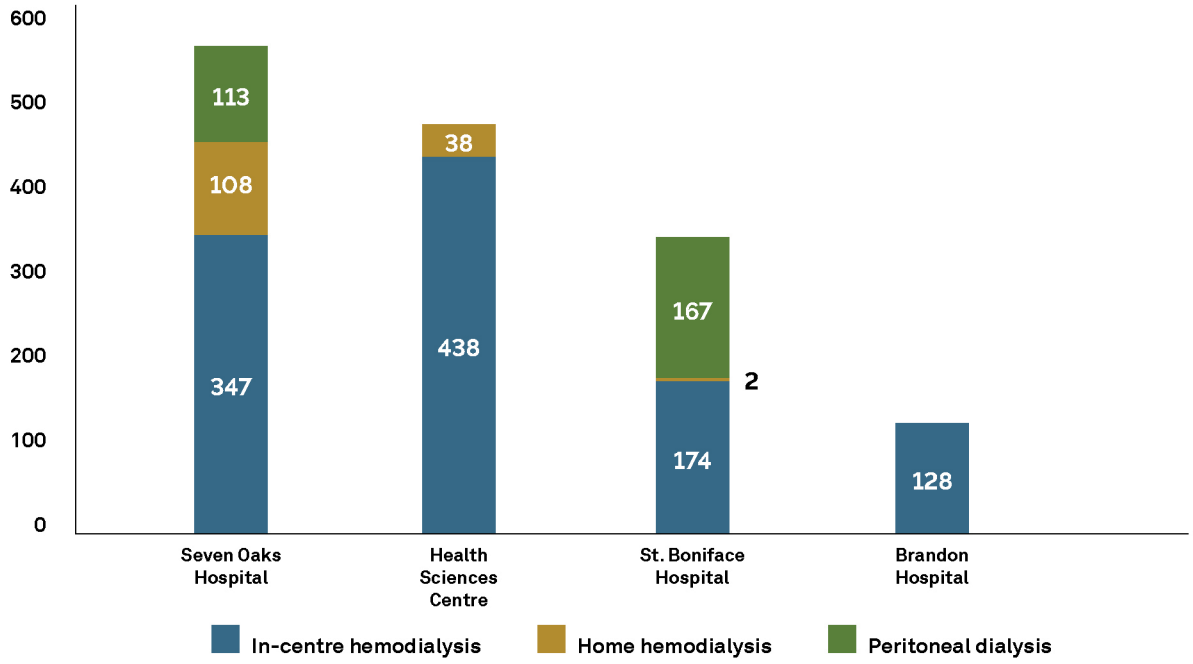
Hemodialysis is either done in a medical facility or, if the patient is able, at home. Peritoneal dialysis is performed by the patient at home.

Modalities are the different ways that dialysis is delivered. Hemodialysis can be provided to the patient in a facility or administered by the patient at their home. Peritoneal dialysis is administered by the patient at their home.

Patients in Manitoba who require dialysis must begin their treatments in Winnipeg or Brandon. Once the patient is stabilized, treatments can continue in a facility in or near their home community, or at home if the patient has the appropriate supports and infrastructure.

Different facilities deliver treatment through different **modalities**, as can be seen in **FIGURE 1**.

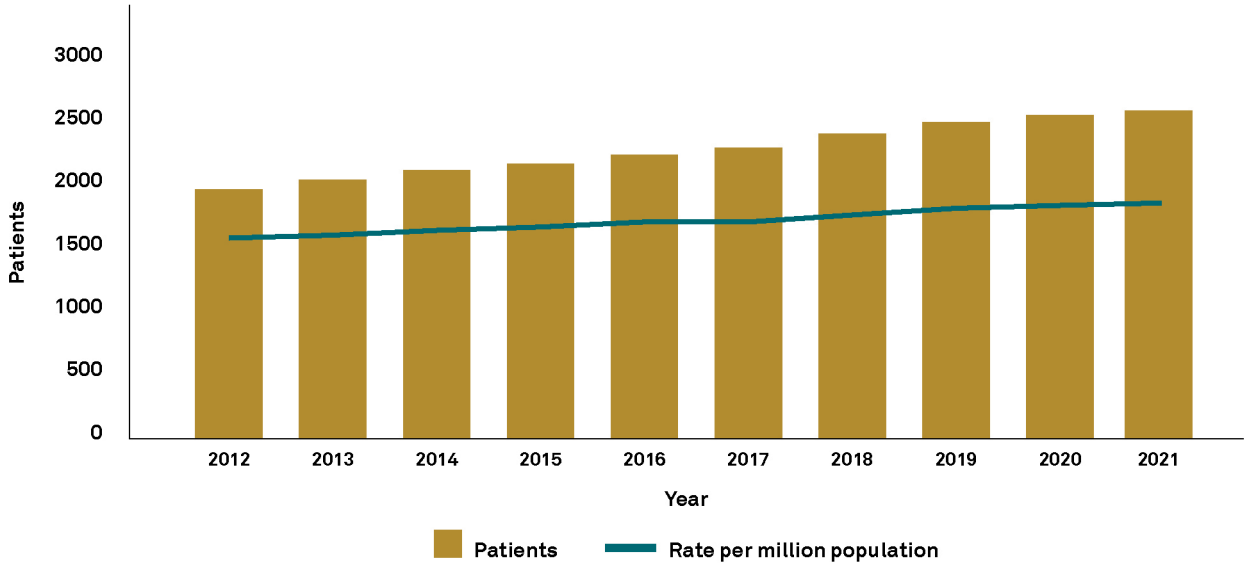
Figure 1 – Average weekly treatments by modality between January 3, 2020 and December 15, 2023



Source: Shared Health weekly status reports

Between 2013 and 2021, Manitoba had the highest rate of end-stage kidney disease patients in Canada—and as shown in **FIGURE 2**, that rate is increasing. As a result, the number of Manitobans requiring dialysis to treat the disease has been increasing. Certain demographics also experience higher rates of the disease. While one in 10 Manitobans have some degree of kidney disease, the rate is one in three for First Nations people. Rural and remote communities are also disproportionately affected. The 2015 Manitoba Centre for Health Policy report, *Care of Manitobans Living with Chronic Kidney Disease*, noted that going forward, increases in the disease would be most pronounced among residents of the Southern Health-Santé Sud and Northern Health Regions.

Figure 2 – Manitoba end-stage kidney disease patients 2012-21



Source: Canadian Institute for Health Information. Treatment of End-Stage Organ Failure in Canada, Canadian Organ Replacement Register, 2012 to 2021: End-Stage Kidney Disease and Kidney Transplants — Data Tables. Ottawa, ON: CIHI; 2023.

As mentioned above, a kidney transplant is a viable treatment for some patients. Donor kidneys can come from either living or deceased individuals. According to data from the Canadian Institute for Health Information, patients in Manitoba wait longer for kidney transplants compared to those in other provinces. As a result, they also remain on dialysis longer.

Roles and responsibilities

Legislation

Under *The Health System Governance and Accountability Act* (the Act), Shared Health is designated as the provincial health authority, and regional health authorities are established. Shared Health and the regional health authorities will be referred to in this report as health authorities, when aspects of dialysis services apply to all these entities.

Shared Health is responsible for:

- Planning in relation to the provincial health system.
- Administering and delivering, or providing for the delivery of, provincial health services, the provincial clinical and preventive services plan, and its strategic and operational plan.
- Administering and delivering, or providing for the delivery of, provincial administrative and support services.

Regional health authorities are responsible for administering and delivering, or providing for the delivery of, health services in their health regions in accordance with the Act, the clinical and preventive services plan, and their own strategic and operational plan. The regional health authorities in Manitoba consist of:

- Interlake-Eastern Regional Health Authority
- Northern Health Region
- Prairie Mountain Health
- Southern Health-Santé Sud
- Winnipeg Regional Health Authority

The Department of Health, Seniors and Long-Term Care

The Department of Health, Seniors and Long-Term Care (the Department) operates under the provisions of the legislation and responsibilities of the Minister of Health. The Department is responsible for:

- Policy, planning, funding and overseeing the health-care system.
- Administering insured health-care benefits for Manitoba residents.
- Issuing Manitoba Health cards.
- Administering the Pharmacare drug benefits program.
- Administering ancillary programs, which have specific eligibility criteria.
- Coordinating public health programs and services.
- Managing the operations of provincial nursing stations.

The Manitoba Renal Program

From 1998 until 2024, the Manitoba Renal Program (the Program) coordinated and delivered kidney health-care services. In 1998, the Program was mandated by Manitoba Health (under the umbrella of the Winnipeg Regional Health Authority) to provide care for all patients receiving dialysis in Manitoba.

The Program handled the planning or strategic functions of kidney health-care services. These included:

- Planning and monitoring province-wide kidney health-care services.
- Developing province-wide clinical standards and guidelines.
- Measuring and reporting on patient and system outcomes.
- Supporting renal staff and patients through education and teaching.

The Program also assessed patients referred to it, decided whether to initiate treatment, and assigned the patients to a specific location for treatment.

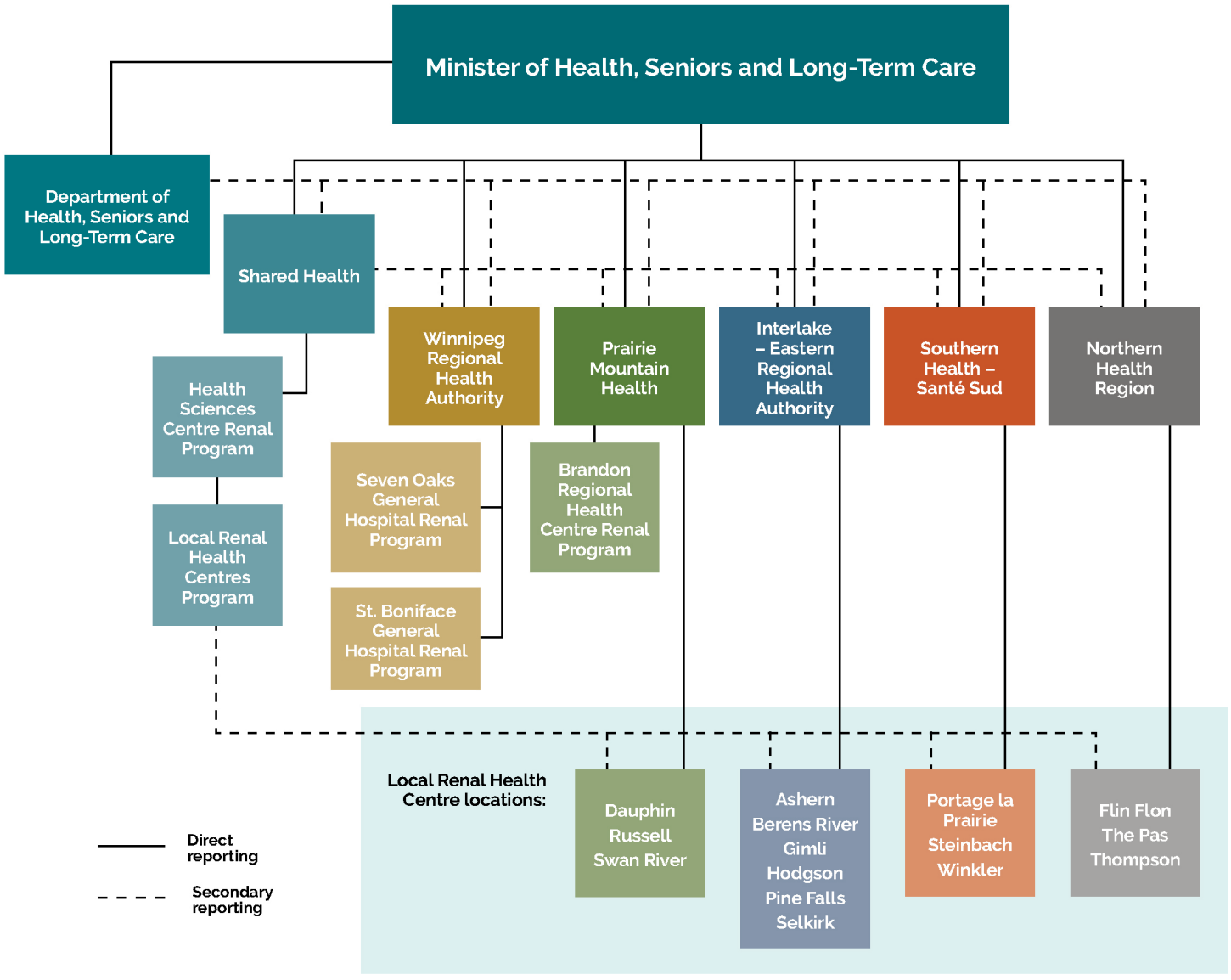
In 2017, work to support health system transformation began when the government committed to the realignment of the health system. This was aimed at improving the quality, accessibility, and efficiency of health-care services. It included commitments to plan provincially, reduce duplicate services, better coordinate service delivery, and create a provincial clinical and preventive services plan. The first step in the realignment was creating Shared Health, which became the provincial health authority responsible for planning Manitoba's health-care system and running the province's **tertiary** centre—the Health Sciences Centre. The creation of Shared Health was guided by the *Health System*

Tertiary services are specialized medical treatments for complex conditions that require advanced equipment and expertise.

Transformation Blueprint. The Blueprint defined each organization's role, responsibilities, and how they would work together to build a more coordinated and responsive health-care system for Manitobans.

Renal care was seen as a province-wide issue, so the Program was transferred to Shared Health on April 29, 2022. Planning and support services responsibilities were separated from service delivery. Shared Health became responsible for planning, while facilities became responsible for service delivery. **FIGURE 3** shows how dialysis services are organized in Manitoba.

Figure 3 – Reporting structure for dialysis services in Manitoba



There are two additional Local Renal Health Centre locations. These are:

- The Norway House Hospital, which is owned and operated by the First Nations and Inuit Health Branch of Health Canada.
- The Island Lake Renal Program, located in Garden Hill, which is operated by Ongomiizwin, the Indigenous Institute of Health and Healing at the Rady Faculty of Health Sciences, University of Manitoba.

Source: OAG developed from information provided by the entities.

A **nephrologist** is a doctor who specializes in the study and treatment of kidneys and kidney conditions.

A **Local Renal Health Centre** is a rural dialysis unit operated in partnership between the Local Renal Health Centres Program at Health Sciences Centre and the Regional Health Authority. The Local Renal Health Centre program is operated to deliver scheduled chronic hemodialysis treatments—it does not provide acute or urgent dialysis. The clinical care delivered in the Local Renal Health Centres integrate the specialized care of the nephrologist, which is provided remotely, and the primary and emergent care of the general physician, which is provided on-site.

Ongomiizwin is the Indigenous Institute of Health and Healing, operated from the University of Manitoba.

See **SECTION 1.1**, and **SECTION 2.2** for further information on the transfer of the Program that went to Shared Health.

Dialysis treatment service providers

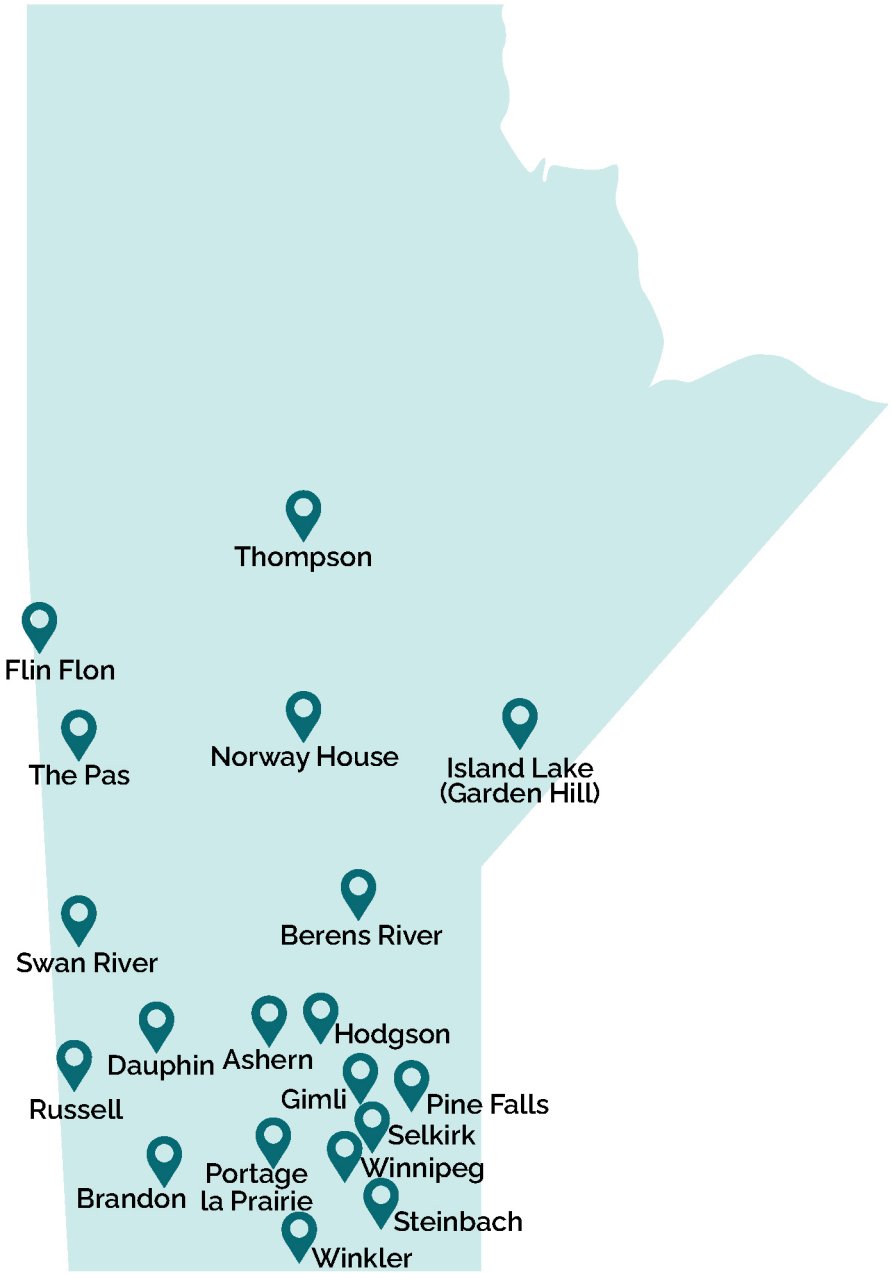
Shared Health (via the Health Sciences Centre) and the regional health authorities (via the dialysis units in their regions) administer dialysis to patients not receiving dialysis at home. They also:

- Support a patient's clinical care including managing emergencies, complications from treatment and underlying disease, and education.
- Support and liaise with a **nephrologist** to align goals of care to a patient's needs.
- Arrange and facilitate follow-up appointments (for example, diagnostics, specialists, and telehealth).
- Facilitate transfer arrangements through the Northern Patient Transportation Program, a provincial government program which subsidizes the travel costs of northern residents to attend required medical appointments for scheduled and emergent needs.
- Connect patients who have non-chronic kidney disease with local health team services to support their needs.

There are 21 in-centre treatment locations in Manitoba that provide dialysis services to patients in a facility setting, as opposed to the patient receiving dialysis in their home. Three locations are in Winnipeg and one is in Brandon. There are also 17 **Local Renal Health Centre** units across Manitoba. Fifteen Local Renal Health Centres are in health facilities operated by local regional health authorities. One Local Renal Health Centre is operated in Island Lake by **Ongomiizwin**, on behalf of the Department, and one is located at Norway House Hospital, operated by the Federal Government. **FIGURE 4** shows dialysis services locations in Manitoba.

All renal and dialysis care for children in Manitoba happens at the Children's Hospital at the Health Sciences Centre in Winnipeg. Pediatric nephrology is its own program and once individuals turn 18, they move to adult dialysis services.

Figure 4 – Dialysis centres in Manitoba



Source: Manitoba Renal Program website

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Objective, scope and approach, and audit criteria

Objective

Our objective was to determine whether dialysis services are managed efficiently.

Scope and approach

The audit examined whether the administrative management functions within the Department of Health, Seniors and Long-Term Care (the Department) and Shared Health are operating in a way that minimizes the effort required to provide dialysis.

We did not assess the:

- Management of the provision of pediatric dialysis, nor other treatments of kidney disease.
- Clinical delivery of dialysis treatments.
- Health transformation process that transferred the Manitoba Renal Program to Shared Health.

To understand the processes and activities in place to manage dialysis, we interviewed management and staff of:

- The Department
- Shared Health
- Each of the 5 regional health authorities
- Ongomiizwin

We visited facilities that provide dialysis at 3 health authorities to observe them and the care that is provided. We spoke with various staff on these visits.

We also reviewed documents, procedures, standards, reports, and other information provided by each of these interviewed entities related to the management of dialysis.

Audit criteria

To determine whether dialysis treatment services are managed efficiently, we used the following criteria:

	Criteria	Sources
1	There is clear strategic direction for the delivery of dialysis treatment services.	• *The Canada Health Act* • *The Health Systems Governance and Accountability Act* • *The Auditor General Act* • *Financial Administration Manual* • *Practice Guide to Auditing Efficiency* • *ISO 37000 – 2021*
2	Responsibilities of each organization delivering dialysis treatment services are clearly defined.	• *The Canada Health Act* • *The Health Systems Governance and Accountability Act* • *Financial Administration Manual* • *ISO 37000 – 2021*
3	The funding process promotes the efficient management of dialysis treatment services.	• *The Canada Health Act* • *The Health Systems Governance and Accountability Act* • *Financial Administration Manual*

Dialysis services are not managed in a manner that promotes efficiency

Dialysis is the primary treatment for patients with end-stage kidney disease. Between 2013 and 2021, Manitoba had the highest rate of end-stage kidney disease patients in Canada—and as shown in **FIGURE 2**, that rate is increasing. As a result, the number of Manitobans requiring dialysis to treat the disease has been increasing.

Our objective was to determine whether dialysis services are managed **efficiently**. Governments would do this by optimizing the use of government funding to achieve their expected outcomes. This would require a **performance measurement framework** which would include:

- Clear strategic direction (planning, monitoring and reporting) for dialysis services.
- Clearly defined responsibilities for each organization delivering dialysis services.
- A funding process that promotes the efficient management of dialysis services.

Planning is one of the most important tasks in management. It is the process where strategic direction and the means to achieve it are determined. It provides a framework to guide departmental activities, provides a practical way to determine **accountability**, and facilitates managing for efficiency. According to the ***Financial Administration Manual***, without planning, management will lose its focus and become more reactive, responding only to crises.

Clearly defined responsibilities and a process to ensure the performance of those responsibilities are important to ensure effective coordination between the various people and organizations contributing to the delivery of services. In Manitoba, Shared Health and the Department of Health, Seniors and Long-Term Care (the Department) both hold responsibility for province-wide planning and delivery of dialysis services.

Efficiency is maximizing results or outputs with minimum effort or inputs.

A **performance measurement framework** is a structured approach used to systematically collect, analyze, and report on the performance of an organization's programs, projects, or initiatives. It helps assess the efficiency and effectiveness of these activities in achieving their desired outcomes, goals, and objectives. The framework typically includes key performance indicators (KPIs), metrics, and benchmarks that provide insights into how well the organization is performing and where improvements can be made. It is designed to support decision-making, enhance accountability, and drive continuous improvement.

Accountability is the obligation to exercise delegated authority to achieve results and the corresponding responsibility to provide justification through normal reporting channels for the results achieved.

The ***Financial Administration Manual***, developed by Treasury Board Secretariat, is the detailed financial policy manual of the Government of Manitoba. Planning is one of the various financial management functions it outlines and provides direction for.

A funding process that allows inefficiencies will always result in waste or not achieving the desired objectives. Therefore, strategic direction and funding decisions should be integrated so that resource determination, allocation, monitoring and control relate directly to program goals and objectives and are done efficiently.

We found that dialysis services are not being managed in a manner that promotes efficiency. We based this conclusion on the following findings:

- There is no operational planning for dialysis services **(SECTION 1)**.
- Responsibilities are established for health care services, but Shared Health has not defined responsibilities for dialysis services **(SECTION 2)**.
- The funding process does not promote the efficient delivery of dialysis services **(SECTION 3)**.

1 No operational planning for dialysis services

An **accountability agreement** is a formal agreement between an organization or individual that is delegating responsibilities to another organization or individual. The agreement is intended to clarify the type of relationship between the two parties, and it should be a joint effort between the two to maximize adherence and compliance, while maintaining accountability. An accountability agreement should provide direction on the deliverables, define responsibilities and standards and define appropriate funding.

Strategic planning includes consideration, at an organization-wide basis, of its:

- Social, technical and economic environment.
- Products, services and the demands and needs of its client groups.
- Alternative approaches to achieving departmental goals.

The health-care system in Manitoba is large and complex, and as such strategic direction is multi-faceted. Strategic direction for the health-care system in Manitoba, and dialysis services specifically, is accomplished through legislation; **accountability agreements**; planning, policies, and standards.

The *Financial Administration Manual* identifies three different levels of planning within the government: **strategic planning, mid-term planning,** and **operational planning**. Strategic planning forms the basis for mid-term plans which identify the resources required to pursue and attain those goals and ultimately leads to the development of operational plans.

The distinction between strategic planning and more detailed mid-term and operational planning is important. Without recognizing this distinction, strategic planning may not receive the emphasis it requires and management risks limiting its actions to reacting to crises. Conversely, operational planning may not be done at a detailed enough level to properly guide the day-to-day activities of the department.

There is strategic planning completed in the health-care system, but for dialysis services, we found:

- No operational plan aligning dialysis services to the strategic direction for health care **(SECTION 1.1)**.
- No monitoring of dialysis services **(SECTION 1.2)**.
- No process to identify efficiencies to include in strategic plans **(SECTION 1.3)**.

1.1 No operational plan aligning dialysis services to the strategic direction for health care

The Health System Governance and Accountability Act (the Act) provides overall direction to the Minister responsible for administering the Act and different organizations in the health sector. The Act requires:

- Shared Health to develop
  - A **clinical and preventive services plan**.
  - A **provincial capital plan**.
  - A **provincial health human resources plan**.
  - Clinical standards for the delivery of health services provided or funded by the government.
- Shared Health and the regional health authorities to develop a strategic and operational plan that must be consistent with the plans noted above.
- All health authorities to enter into accountability agreements with the Minister.

As discussed below, the clinical and preventive services plan provides strategic direction for overall health services. The objectives noted in it are relevant for all program areas including dialysis services. However, the clinical and preventive services plan is not specific to dialysis services and is not intended to be at the program level. Operational direction at the program level for dialysis was developed in the past but has not been kept current.

Mid-term planning is a refinement of the strategic plan and links it to the programs and policies in place to achieve the strategic objectives. The results of mid-term planning should clearly:

- Define organizational direction.
- Highlight environmental factors.
- Describe current program operations and their results.
- Identify opportunities for program reductions and new initiatives.

Operational planning converts strategy, mid-term plans and resourcing decisions into detailed, short-term, results-oriented plans. These include:

- A clear link between operational objectives and program objectives stated in the mid-term plan.
- And a description of the key results and their measurement criteria supporting operational objectives, including performance indicators.

The **clinical and preventive services plan** is a five-year plan, required by the Act, to be prepared by Shared Health, respecting the delivery of health services in Manitoba.

The **provincial capital plan** is an annual plan, required by the Act, to be prepared by Shared Health, that is based on the provincial clinical and preventive services plan.

The **provincial health human resources plan** is a plan, required by the Act, to be prepared by Shared Health, respecting human resource requirements for the delivery of health services in Manitoba as set out in the provincial clinical and preventive services plan and in the Act, including workforce planning, labour relations and recruitment and retention of health care providers and other professionals.

Clinical and preventive services plan provides strategic direction for overall health services

As required by the Act, Shared Health developed the five-year clinical and preventive services plan in 2019. It is considered the strategic plan for the health-care system for Manitoba, and for the Department. While it is not specific to the delivery of dialysis services, it includes broader goals that are relevant to all program areas, including dialysis, such as:

- Provincial clinical governance.
- Clear roles and responsibilities in the network model.
- Enhanced community supports.
- Innovative approaches to care through digital health.
- Coordinated provincial access.

The clinical and preventive services plan references renal care and dialysis in a section on chronic and complex medicine as kidney disease is a chronic condition. The plan does not outline any specific actions or objectives specific to renal care or dialysis as those would be expected to be included in operational plans or program plans.

The chronic and complex medicine section of the plan provides data on the current state of the health-care system and outlines a future vision. The future vision is summarized in the following statements:

- It will be easier to know where to go for care.
- People will have access to appropriate information about their health needs.
- Providers will work together to coordinate people's care.
- People's wait times and unnecessary travel will be reduced.
- People will be more involved in the management of their own care.
- Care will be provided closer to home.

There was planning for dialysis in the past, but none during our audit period

Prior to our audit period, and prior to the creation of Shared Health, the Manitoba Renal Program (the Program) was operating under the umbrella of the Winnipeg Regional Health Authority and provided direction for dialysis services. In 2014, it developed a three-year plan that identified **strategic priorities**. It also identified a **mandate** and **goals** on its website. We did not assess the quality of that plan or the mandate and goals identified on the website.

The **mandate** of the Manitoba Renal Program, as identified on its website, was to:

- Provide adult clinical care and education regarding all aspects of acute and chronic renal or kidney disease.
- Plan and monitor province-wide kidney care services.
- Develop province-wide clinical standards and guidelines.
- Measure and report on patient and system outcomes.
- Support renal staff and patients through education and teaching.

The **goals** were to:

- Deliver high quality kidney health-care services to Manitobans.
- Improve early diagnosis and treatment of chronic kidney disease.
- Promote prevention of chronic kidney disease through education.

The **strategic priorities**, as noted in the 2014 plan were to:

- Optimize chronic kidney disease prevention through improved surveillance, screening and risk-based intervention.
- Optimize treatment options for end-stage kidney disease and improve utilization of lower cost-effective modalities.
- Strengthen chronic kidney disease care through research and innovation.
- Enhance patient involvement in management of care.

Responsibility for a portion of the Program was transferred to Shared Health on April 29, 2022 (see **BACKGROUND** for additional information). As a result, Shared Health became responsible for dialysis services planning, which is a provincial health service. Shared Health did prepare a Strategic and Operational Plan, as required by the Department in each year of our audit period. However, these Strategic and Operational Plans did not:

- Convert the overall strategic direction found in the clinical and preventive services plan into more detailed, short-term, results oriented plans for dialysis services.
- Provide a clear link between operational objectives for dialysis services and objectives stated in the clinical and preventive services plan.
- Include a description of the key results and their measurement criteria supporting operational objectives, including performance indicators.

These strategic and operational plans do not clearly align with the strategic direction for health care. This lack of current operational planning has resulted in unclear expectations within dialysis services (as shown in **SECTION 2.2**).

Recommendation 1

We recommend that Shared Health develop an operational plan that aligns dialysis services to the strategic direction for health care that includes clear, outcome-oriented goals and required reporting.

1.2 No monitoring of dialysis services

Department monitors the overall health system

To foster accountability in the health system, the Department **monitors** the performance of the health authorities' progress against the accountability agreements required by the Act and provincial objectives. As part of this monitoring, the Department has developed a performance management framework which outlines the approach to organize and align improvement, track progress, assess the need for additional investment, and highlight successes aligned with the Act. This is based on information provided by the health authorities and considered in collaboration with health authority leadership.

As outlined in **SECTION 2.1**, the accountability agreements between health authorities and the Minister include renal/dialysis care as one of the services the health authorities are expected to provide. However, these agreements provide minimal direction for renal/dialysis care. Because there is little reference to dialysis in both the accountability agreements and broader provincial objectives, departmental monitoring activities generally do not touch on dialysis services.

Shared Health not fulfilling its legal requirement to monitor and evaluate

Under the Act, Shared Health is responsible for monitoring and evaluating the implementation of the provincial clinical and preventive services plan. Although it has this responsibility, Shared Health has not done this.

Additionally, under the ***Financial Administration Manual***, management is responsible for monitoring the activities taken to achieve the goals identified in the operational plan. Shared Health

Monitoring is the ongoing process of collecting and analyzing information to determine whether objectives are being met.

The ***Financial Administration Manual*** requires the analysis and assessment of results compared to plans. It says it is important that plans are reviewed and reconciled annually with the strategic and mid-term plans, resourcing decisions and any changes in the environment. Further, departments must establish and maintain systems to monitor how much they are spending compared to how much has been budgeted, which will allow them to identify and explain variances between actual and planned expenditures as well as how program activity is varying from those planned. This analysis and assessment of results is important to ensure that decision makers have the information they need to determine whether objectives have been met and whether plans need to be changed in the future.

was able to provide us with some information that could be used in monitoring and evaluation activities such as number of treatments per location and wait list data. However, because the operational plan has not been developed for dialysis services, this monitoring and evaluation of progress to achieve operational goals has not been done.

Although monitoring may not prevent the inconsistent provision of services, monitoring will include documentation of the non-compliance and allow that information to be available to decision makers. In this case Shared Health should escalate this information to the Minister to determine necessary follow-up actions.

Policies are developed to further clarify intentions and expectations found in strategic direction documents, such as strategic plans or accountability agreements, and provide guidance on how these responsibilities are to be fulfilled. Despite the many policies meant to provide direction for dialysis services, we found examples of inconsistent provision of services:

- Supplements such as calcium and other over-the-counter medications are not consistently provided according to policy. As a result, some patients incur an out-of-pocket expense while others do not.
- Some individuals transferred to other dialysis units due to capacity issues had the cost of transportation paid for by either the site or a third party. In other cases, the cost and responsibility for getting to and from dialysis were the responsibility of the patient.

Recommendation 2

We recommend that Shared Health monitor and evaluate:

- The implementation of the clinical and preventive services plan by the authorities.
- Achievement of the goals identified in the plan for dialysis services developed in **RECOMMENDATION 1**.

Shared Health reporting not linked to goals for dialysis services

The *Financial Administration Manual* states that reports must be prepared on the progress made toward achieving key results and objectives. A system of management reporting, which produces timely, results-oriented information, is fundamental to the control process. This system of reporting is part of the performance measurement framework that should be in place to manage a system efficiently.

The Act requires the health authorities to produce annual reports. These annual reports are to include details about the activities of the health authority in relation to the health services provided or funded by the authority, and the cost of these activities. While these reports are produced, the annual report Shared Health produced does not include all of the details about the activities that it is funded to perform. Shared Health did not monitor and evaluate the implementation of the clinical and preventive services plan or compliance with standards. The Department also produces an annual report. However, since there are no strategic objectives related to dialysis services (as identified in **SECTION 1.1**), these annual reports do not report on details related to dialysis services.

Staff at Shared Health currently produce a weekly status report on dialysis services, which is available to the health authorities. It reports the capacity (both physical and operating) of each unit, the number of patients receiving dialysis in each unit, the number of treatments, the number of patients on the waitlist, and the number of patients receiving each type of dialysis. Without current strategic objectives at the program level we cannot determine whether this report includes the necessary information or data to measure performance of dialysis services.

In 2019 and 2020, the Program produced a "year in review snapshot" document. This was prior to our audit period, and prior to being transferred to Shared Health from the Winnipeg Regional Health Authority. These snapshot documents provided a summary of the activities and outputs of the system, however, did not report outcomes on the goals or objectives the Program had previously established.

Recommendation 3

We recommend that the Department and Shared Health collect, analyze, and report the data necessary to measure the achievement of the strategic goals developed in **RECOMMENDATION 1** and the performance of the health authorities in providing dialysis services.

1.3 No formal process to identify efficiencies to include in strategic plans

The mid-term planning function is designed to assess program options and to establish program priorities to guide the allocation of resources. As part of this, the results of mid-term planning should identify opportunities for efficiencies. We noted that the strategic planning process lacks formal consideration to consistently identify opportunities to improve efficiency in service delivery.

Efficiencies in dialysis services can be achieved by reducing the number of patients needing dialysis as well as the resources required to provide dialysis. Any potential initiatives identified, if assessed to be worthwhile, could then be included in strategic planning objectives and carried through in operations.

Shared Health is aware of some potential efficiencies. One potential efficiency is to implement an electronic health record system. The use of paper files is inefficient, as manual transporting, updating, sorting, and recording in the file is time consuming and more expensive. Additionally, physical files restrict access to a single location, preventing multiple care providers (such as doctors, nurses or **allied health professionals**) from accessing the files from different locations.

Other initiatives that are being considered include greater use of data analytics to guide activities and increasing the use of home hemodialysis, specifically in personal care homes. Although these initiatives are being considered, it is in an ad hoc manner and there is no regular assessment of initiatives that would create efficiencies.

Allied health professionals are health professionals, distinct from medicine and nursing, that are involved with the identification, evaluation and prevention of diseases and disorders.

In Manitoba, the allied health professionals related to dialysis include pharmacists, dietitians, and social workers.

Recommendation 4

We recommend that Shared Health implement a formal process to identify efficiencies to inform the development of the strategic direction in **RECOMMENDATION 1**.

2 Responsibilities for dialysis services not clearly defined

The administration of government involves the functions and activities of many different people and organizations. In strategic planning for a system as complex as the health system, responsibilities are delegated to many people, and in many situations further delegated to others. **FIGURE 3** (in the **BACKGROUND**) shows the complex reporting structure of dialysis services within the health system in Manitoba.

To ensure accountability, it is necessary to be able to demonstrate, and take responsibility for, performance according to agreed upon expectations. The better defined the responsibilities and related processes are, the greater the accountability can be.

The *Financial Administration Manual* describes the responsibilities for departmental financial management and states that operational plans should include responsibilities and individuals accountable for them. And each of the health authorities, including Shared Health, are delegated responsibility under *The Health System Governance and Accountability Act* (the Act) to prepare strategic and operational plans. Therefore, we expected that there would be strategic plans at the province-wide level that would identify responsibilities broadly and operational plans within each of the organizations that would identify the more specific responsibilities, such as responsibilities for dialysis services.

We found that:

- Responsibilities for health services are defined, but not at a dialysis services program level **(SECTION 2.1)**.
- Shared Health has not defined responsibilities related to dialysis services **(SECTION 2.2)**.
- Accountability processes for non-performance are defined **(SECTION 2.3)**.

2.1 Responsibilities for health services defined, but not at dialysis services program level

General responsibilities for departments in the administration of government are outlined in policy manuals such as the *Financial Administration Manual*. Overall responsibilities for providing health services are delegated to the health authorities in the Act, other legislation and the accountability agreements.

Shared Health, as the provincial health authority, is delegated responsibilities by the Act for:

- Planning in relation to the provincial health system, which includes:
  - Establishing clinical standards for the delivery of health services.
  - Managing and allocating resources including funding provided by the government for health services.
  - Monitoring and evaluating the implementation of the clinical preventive services plan.
  - Preparing an annual provincial health capital plan.
  - Developing a provincial health human resource plan.
- Administering and delivering provincial health services.
- Administering and delivering provincial administrative and support services.

Each regional health authority is delegated responsibilities for:

- Administering and delivering health services in its health region.
- Promoting and protecting the health of the population of its health region and developing and implementing measures for the prevention of disease and injury.
- Managing and allocating resources for health services.
- Monitoring and evaluating its compliance with the clinical and preventive services plan.

The Act also requires health authorities to enter into accountability agreements with the Minister responsible for administering the Act. These should provide further direction on deliverables and responsibilities. All the health authorities, except for Shared Health, have signed their accountability agreements for our audit period.

The accountability agreements identify renal/dialysis care as one of the core services that the health authority is expected to provide. They provide further direction in a list of standards and policies that apply to the health authority. This list includes only one that is specifically related to dialysis, and it is for a very specific situation. The accountability agreements also state that services are to be provided in a manner consistent with:

- The clinical and preventive services plan.
- Prescribed standards, policies and guidelines established by Manitoba.
- Clinical standards established by Shared Health.

As identified in **SECTION 1**, the strategic planning function is separated into different levels, with specific programs or tasks being identified in operational plans. As such, the responsibilities outlined in the Act do not identify dialysis activities specifically but are assumed to include them generally. In addition, the mention of dialysis services in the accountability agreements is general in nature. Therefore, it would be reasonable to expect dialysis-specific responsibilities to be defined in operational plans, or procedure manuals developed to implement operational plans. We have identified, in **SECTION 1.1**, that there is no operational plan aligning dialysis services to the strategic direction for health care.

2.2 Shared Health has not defined responsibilities related to dialysis services leading to uncertainty in the system

Shared Health is responsible for administering provincial health services. However, there is disagreement and uncertainty within the dialysis system regarding who is responsible for many of the functions.

In the past, the Manitoba Renal Program (the Program) defined responsibilities regarding dialysis. A portion of the Program was transitioned to Shared Health as part of the health transformation process, as renal care is considered a provincial health service. Under the Act, Shared Health is responsible for planning in relation to the provincial health system and administering provincial health services. As identified in **SECTION 1.1**, Shared Health has not performed any strategic planning for dialysis services since the Program was transitioned to it.

Shared Health intends to set up a new Kidney Health Provincial Clinical Team Sub Committee to perform some of these tasks. The responsibilities of this sub committee, as identified in its recently drafted terms of reference, will be to:

- Identify gaps related to kidney health within the province.
- Prioritize planning related to Kidney Health and dialysis in the province related to Population Health needs, government/Health System priorities and priorities identified in the clinical and preventive services plan reflecting sustainable, patient oriented and culturally safer solutions.
- Create provincial clinical pathways, standards, guidelines, and order sets, for specific aspects of kidney health, inclusive of dialysis, that are in line with delaying progression of disease, best practice and improve outcomes for patients and patient flow and cultural safety.
- Collaborate in planning with Transplant Manitoba
- Develop, implement, and monitor provincial quality metrics and dashboards for kidney health that are in line with best practice.

Carrying out these responsibilities, along with the development of a strategic and operational plan as required by the Act, should further delineate responsibilities to be carried out by individuals or facilities related to dialysis services.

This lack of defined responsibilities is evident as there were disagreements and questions among staff and management within the dialysis system regarding who is responsible for many of the functions within the system.

Local Renal Health Centre Operating Manual is the operating manual for the Local Renal Health Centre program operated from the Health Sciences Centre developed prior to the transfer of the Program to Shared Health. The Local Renal Health Centre program is operated to deliver scheduled chronic hemodialysis treatments; it does not provide acute or urgent dialysis. The clinical care delivered in the Local Renal Health Centres integrate the specialized care of the nephrologist, which is provided remotely, and the primary and emergent care of the general physician, which is provided on-site.

Prior to the transfer to Shared Health, the ***Local Renal Health Centre Operating Manual*** noted functions with individuals, entities, or committees identified as being responsible for those functions. We identified 27 of these functions and asked two different members of management within the system who was responsible for these functions during our audit period. There was disagreement or uncertainty on 22 of the 27 functions.

The Program had a Professional Advisory Committee and a Policy and Procedure Committee prior to the transfer. These are no longer active and were not active during our audit period. This has resulted in an inability to update policies and procedures in a timely manner, and uncertainty among facility staff as to when they should take direction from Shared Health and when they should create their own policy.

Recommendation 5

We recommend that Shared Health, once it has prepared the strategic direction as outlined in **RECOMMENDATION 1**, clearly define the responsibilities of individuals and facilities for dialysis services.

2.3 Accountability processes for non-performance are defined

An accountability framework should include processes that allow the party that has been delegated responsibilities to be held accountable for non-performance of those responsibilities. **The Act** gives the Minister the authority to establish provincial objectives and priorities for the provision of health services in Manitoba. Within that accountability framework established by the Act, some responsibilities for monitoring the performance of delegated responsibilities are given to Shared Health. The Minister also delegates some monitoring responsibilities to the Department.

Legislation gives the Minister the authority to hold the health authorities **accountable** by:

- Requiring revisions to the strategic plan.
- Withholding funding.
- Appointing an official administrator to act in the place of the health authority and its board.
- Recommending to the Lieutenant Governor in Council to amalgamate regional health authorities.

The Health Governance and Accountability Act notes that its purposes include:

- To govern the planning, administration, and delivery of health services in Manitoba.
- To establish an accountability framework for the health authorities and the entities funded by the authorities.

Accountability is the obligation to exercise delegated authority to achieve results and the corresponding responsibility to provide justification through normal reporting channels for the results achieved.

The Department has developed some additional procedures within their monitoring process for non-performance, while Shared Health has not started to fulfill their monitoring responsibilities.

Department monitoring processes include escalation where improvement is needed

The departmental monitoring framework (described in **SECTION 1.2**) includes a process to evaluate the health authority's performance in various areas. When improvements are needed, the framework includes escalation measures such as closer monitoring, more frequent reporting and meetings, and increased involvement from executive health leadership.

Based on the audit work we performed, we found that none of these departmental monitoring processes have been at the detailed level of dialysis services. Furthermore, as there are no goals or objectives specific to dialysis services within the health system, and none of the departmental branches were focused on dialysis services, we did not audit any of these processes.

3 Funding process does not promote efficient delivery of dialysis services

Efficiency is maximizing results or outputs with minimum effort or inputs. In order to measure and promote efficiency, both the outputs and inputs need to be known. Outputs, in this case, would be results of the program as they relate to the strategic priorities and goals outlined in the planning process, while inputs are the costs, including labour, supplies and capital, related to achieving those outputs.

Strategic planning usually involves a significant commitment of financial and physical resources, as well as time. To ensure that the financial implications of these plans are within the financial resources available, the costs of the planned activities should be understood prior to the plans being adopted. If the financial resources are not available, then the plans may need to be adjusted to something that is achievable.

The Department of Health, Seniors and Long-Term Care (the Department) provides health authorities with operating and capital funding for dialysis. Capital funding includes a provision for initial operating funding once the capital project is complete.

Dialysis operating expenses and funding related to dialysis provided to health authorities are outlined in **APPENDIX 1**. These expenses include salary and benefit compensation for non-doctors, medical and surgical supplies, and drugs.

Additionally, doctors bill the Department for services provided based on a fee schedule, which is negotiated every three to four years and updated quarterly. The amounts paid to doctors for dialysis services amounted to $15.9 million in 2021/22, $15.7 million in 2022/23, and $15.6 million in 2023/24.

According to the *Financial Administration Manual*, as part of the planning process, operational plans should include:

- A reconciliation with the results and the incorporation of the decisions made during the resource allocation process. We interpret this to mean that funding should be tied directly to the strategic objectives.
- A costing of associated staff and financial resources for each project, process, or activity. We interpret this to mean that input costs of a project, process, or activity should be determined.

Therefore, we expected that funding for dialysis services would tie directly to the strategic objectives and goals outlined within the various planning documents, and expenses would be analyzed to ensure that efficiency is achieved.

We were unable to tie the funding for dialysis services directly to strategic objectives or observe an analysis of the dialysis expenses.

Specifically, we found that:

- Annual funding is not based on strategic expectations (**SECTION 3.1**)
- Input costs are not analyzed to inform funding and efficiency (**SECTION 3.2**)

3.1 Annual funding not based on strategic expectations

Annual funding to the individual health authorities is determined using a standard process. The Department requests each health authority to prepare an annual operating plan, which is a requirement of the Act, and provides them with guidance on how to prepare it. The guidance, and therefore the resulting operating plans, is designed to identify the funding needed to provide services. This process begins a year in advance for the following fiscal year.

The operating plan consists of **core sections** that provide the Department with the organization's essential financial requirements. This description of needs is at a high level (for example, by sector or expense type such as acute care, and not by program, such as dialysis). Each section consists of a financial schedule, as well as a narrative which is expected to provide further content and clarify details provided in the schedule. These details may include briefly describing high-level pressures, requests and/or strategies to balance their expenses to funding; impact on service delivery/clients; assumptions/calculations used to determine change; historic information that may provide further context; etc. The financial schedule is expected to articulate the financial requirements for each topic.

The Department's guidance to the health authorities also says that annual operating plans are required to demonstrate intended progress towards strategic plans and system priorities.

The **core sections** of the operating plan include:

- A summary
- Wage cost increases
- Increases to maintain current health authority services
- Supply price increases
- Drug price increases
- Capital operating requirements
- Strategies to balance
- Medical remuneration
- Other revenue

Performance expectations identified in the Act also require the health authorities to provide services according to the strategic plans. Specific performance expectations identified in legislation for the health authorities include:

- Delivering health services in accordance with the authority's strategic and operational plan, which must be consistent with the clinical and preventive services plan, the provincial health human resources plan, and the provincial capital plan.
- Managing and allocating resources in accordance with the authority's strategic and operational plan.

However, the health authorities have been instructed in the guidance to maintain their funding needs within a flat percentage increase, with additional funding provided for specific provincial mandates and priorities outside of normal operations. This could be contradictory guidance if strategic plans and system priorities cannot be achieved within the specific flat percentage increase. In this situation, either the plans and priorities won't be achieved or the flat percentage increase will need to be increased. Alternatively, if the flat percentage increase is more than is needed, there could be unnecessary expenditures due to less pressure to control costs and a reduced drive for efficiency and performance improvements.

The ***Financial Administration Manual*** states "Planning and control systems consist of two distinct, yet fully interrelated processes:

- Program planning and control; and
- Financial planning, budget preparation and control.

It is essential that these two processes be fully integrated so that the mechanisms which are used for resource determination, allocation, monitoring and control bear a direct relationship to program goals and objectives and the development and execution of operational plans."

The **annual operating plan** guidance states that:

- "SDOs will demonstrate that resources are deployed to maximum effect and aligned with provincial and local system priorities."
- "SDOs are expected to set out ambitious plans to:
  - Improve value for money, increase efficiency and reduce waste and unwarranted variation."
  - Accelerate technical efficiency programs that will deliver better quality of care and more effective workflow at lower cost."

3.2 Input costs not analyzed to inform funding and efficiency

No calculations of input costs to inform funding

The ***Financial Administration Manual*** identifies financial planning and budget preparation as key financial activities that are important when doing operational planning. These key financial activities include identifying the types and level of activity planned, unit costs, and costing formulae. This is also an expectation of the **annual operating plan** guidance.

Identifying and valuing the inputs in a system are important to determine and assess the efficiency of operations. This could be done through a comparison over time or against some other predetermined standard. Efficiency is achieving maximum productivity with minimum effort or expense. This identification and valuation is not happening within dialysis services.

Neither the Department, Shared Health, nor any of the Regional Health Authorities have performed any form of analysis of input costs.

As an example, one analysis could involve determining the appropriate staffing levels required for a Local Renal Health Centre to operate effectively. This would ensure that the centres comply with the *Local Renal Health Centre Operating Manual*. The manual includes, in the Memorandum of Agreement template, a clause that requires the regional health authority to "ensure adequate staffing, as recommended by the Manitoba Renal Program, and shall also ensure adequate staffing coverage for vacation and sick relief…".

In relation to determining adequate staffing, we note that at least one other province has determined expected patient to caregiver ratios for at least one of the different types of caregivers. Performing this type of calculation, or something similar, on a province-wide basis would help in determining appropriate funding levels and allow health authorities a predetermined standard to assess their operations against.

No analysis of actual costs to assess efficiency

The Department also does not compile and compare actual financial information on dialysis services to assess reasonableness across the system. The Department informed us that it oversees the overall performance of the health authorities and that specific information on dialysis services is the responsibility of Shared Health. Department management stated that it monitors spending on **protected programs**, such as dialysis, but this is limited to assessing program expenses within individual health authorities against their individual budget numbers.

Protected programs are program line items funded by the Department, where the health authority does not have the flexibility to reallocate funding from the program to other areas within their budget.

Shared Health also has not compiled and compared actual financial information on dialysis treatments.

The five regional health authorities track total actual costs and compare that to their internal budget. One regional health authority has calculated its cost per treatment as part of its cost centre reporting. Additional treatment cost analyses that could be performed to assess efficiency would include a multi-year analysis of costs, comparisons to benchmarks, or comparisons to other jurisdictions.

We calculated the in-centre cost of treatment for dialysis for each of the health authorities. We did this by dividing their total in centre dialysis costs by the number of treatments provided during the year. The calculations were based on information provided to us by the health authorities and our results are presented in **FIGURE 5**. Similar analyses would be useful for the Department and each of the health authorities. It would help guide decision making and provide accountability information on variation between regions and over time. This analysis could identify where or when there are inconsistencies such as significant changes over time within an authority, or differences between authorities. Further investigation could determine why that is happening and what changes should occur as a result.

Figure 5: Cost per in-centre treatment			
Health Authority	**2021/22**	**2022/23**	**2023/24**
Shared Health	$395	$380	$395
Winnipeg Regional Health Authority	$401	$398	$408
Prairie Mountain Health	$350	$368	$384
Interlake-Eastern Regional Health Authority	$318	$341	$368
Northern Health Region	$409	$405	$473
Southern Health-Sante Sud	$263	$264	$323

Source: Health authorities unaudited variance analysis reports

Recommendation 6

We recommend that the Department of Health, Seniors and Long-term Care use cost analyses of dialysis treatments to inform funding to be provided to health authorities for dialysis services.

Additional information about the audit

This independent assurance report was prepared by the Office of the Auditor General of Manitoba on the management of dialysis services. Our responsibility was to provide objective information, advice and assurance to assist the Legislature in its scrutiny of the government's management of resources and programs, and to conclude on whether the Department and Shared Health comply in all significant respects with the applicable criteria.

All work in this audit was performed to a reasonable level of assurance in accordance with the *Canadian Standard on Assurance Engagements (CSAE) 3001—Direct Engagements* set out by the Chartered Professional Accountants of Canada (CPA Canada) in the *CPA Canada Handbook —Assurance*.

The Office applies Canadian Standard on Quality Management 1, which requires the Office to design, implement and operate a system of quality management, including policies or procedures regarding compliance with ethical requirements, professional standards, and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the *Code of Professional Conduct of the Chartered Professional Accountants of Manitoba*, which are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behavior.

In accordance with our regular audit process, we obtained the following from management:

- confirmation of management's responsibility for the subject under audit.
- acknowledgement of the suitability of the criteria used in the audit.
- confirmation that all known information that has been requested, or that could affect the findings or audit conclusion, has been provided.

Period covered by the audit

The audit covered the period between April 29, 2022 and March 31, 2024. This is the period to which the audit conclusion applies. However, to gain a more complete understanding of the subject matter of the audit, we also examined certain matters that preceded the audit coverage period.

Date of the audit report

We obtained sufficient and appropriate audit evidence on which to base our conclusion on December 1, 2025, in Winnipeg, Manitoba.

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Summary of recommendations and response from officials

This section provides a summary of all the recommendations we made, along with the responses from Shared Health and the Department of Health, Seniors and Long-Term Care.

Recommendation 1

We recommend that Shared Health develop an operational plan that aligns dialysis services to the strategic direction for health care that includes clear, outcome-oriented goals and required reporting.

Response of Shared Health:

Shared Health accepts this recommendation. Shared Health dedicated leadership to establish and support a Kidney Health Subcommittee within its Provincial Medicine Program in the spring of 2024. An initial year one work plan was developed and implemented. A Provincial Kidney Health Clinical Plan is now in development and is targeted for completion by early 2026. Both the initial year one workplan and the Kidney Health Clinical Plan include dialysis services.

Response of Manitoba Health, Seniors and Long-Term Care:

Shared Health has initiated work on a Provincial Kidney Health Clinical Plan in collaboration with the regional health authorities and under the oversight of the department. The plan will include strategic goals for the program, a provincial forecasting of dialysis patient needs, and monitoring of dialysis services delivered across the province. The department will monitor Shared Health's completion of the provincial plan, which is anticipated to be completed by early 2026. It will also work with the regional health authorities to ensure their engagement and alignment with provincial program planning and management.

Recommendation 2

We recommend that Shared Health monitor and evaluate

- The implementation of the clinical and preventive services plan by the authorities.
- Achievement of the goals identified in the plan for dialysis services developed in **RECOMMENDATION 1**.

Response of Shared Health:

Shared Health accepts this recommendation and reaffirms its commitment to the following:

1. Monitoring and evaluating the implementation of the clinical and preventative services plan.
2. Monitoring the performance of dialysis services by Regional Health Authorities, including recommending to the department the optimal allocation of financial resources for dialysis across the Regional Health Authorities, in keeping with duties of the provincial health authority as outlined in Section 23(2)(g) of *The Health System Governance and Accountability Act* C.C.S.M. c. H26.5.

In May, 2024 Shared Health aligned the operations of the Manitoba Renal program with the provincial clinical planning function within the Shared Health organizational structure which is now referred to as Kidney Health Manitoba. A draft 5-year clinical plan for Kidney Health is now nearing completion, and the plan includes a framework and indicators for monitoring performance and evaluating progress towards the priorities of the Kidney Health Plan. Shared Health will strengthen its current Health Authority reporting to monitor and evaluate the implementation and impact of the Kidney Health Clinical Plan.

Response of Manitoba Health, Seniors and Long-Term Care:

The department will continue to oversee all regional health authorities' implementation of the clinical and preventive services priorities, and achievement of the department's goals for the health system.

In order to ensure achievement of strategic goals for kidney health and dialysis services, the department will affirm its expectation of all regional health authorities to align their activities with the Provincial Kidney Health Clinical Plan and to meet the identified strategic goals for kidney health and dialysis services outlined by both Shared Health and the department.

Recommendation 3

We recommend that the Department and Shared Health collect, analyze, and report the data necessary to measure the achievement of the strategic goals developed in **RECOMMENDATION 1** and the performance of the health authorities in providing dialysis services.

Response of Shared Health:

Shared Health accepts this recommendation and together with Manitoba Health, Seniors and Long-Term Care, have been engaged in collecting, analyzing and reporting dialysis data. Work is now underway to align this to the strategic goals developed in the Kidney Health Clinical Plan.

Response of Manitoba Health, Seniors and Long-Term Care:

The department will work collaboratively with Shared Health to establish key performance indicators for dialysis services, that measure achievement of the strategic goals for the program and the operational implementation of service targets for kidney health (including those for primary prevention, early intervention, and providing services closer to home).

This will include development of a reporting and monitoring framework that distinguishes between indicators to be monitored by Shared Health (clinical and operational), and those that will be monitored by the department (financial and strategic). The department will integrate monitoring of provincial renal health and dialysis program performance into the Performance Management Framework for the health system.

Recommendation 4

We recommend that Shared Health implement a formal process to identify efficiencies to inform the development of the strategic direction in **RECOMMENDATION 1**.

Response of Shared Health:

Shared Health accept this recommendation. This process has been undertaken over the past year and has informed the Kidney Health Clinical Plan to be completed by early 2026.

Response of Manitoba Health, Seniors and Long-Term Care:

The department expects that Shared Health will incorporate a process for identifying efficiencies in kidney health and dialysis services, into its collaborative planning processes with the regional health authorities and will provide oversight to ensure this occurs.

The department will use the outcomes of this efficiency process to inform its performance oversight and direction to the regional health authorities on kidney health services.

Recommendation 5

We recommend that Shared Health, once it has prepared the strategic direction as outlined in **RECOMMENDATION 1**, clearly define the responsibilities of individuals and facilities for dialysis services.

Response of Shared Health:

Shared Health accepts this recommendation. The Clinical Control Documents Committee (Policy and Procedure Committee) has been re-established to update policies and procedures and refresh the Local Renal Health Centre Operating Manual. Responsibilities of individuals and facilities will be reviewed and clarified by June 2026.

Response of Manitoba Health, Seniors and Long-Term Care:

The department expects that Shared Health will use its clinical governance structures (i.e., the provincial clinical team for Kidney Health) to develop clinical standards and operational policies and procedures for dialysis services, collaboratively with the regional health authorities.

Recommendation 6

We recommend that the Department of Health, Seniors and Long-term Care use cost analyses of dialysis treatments to inform funding to be provided to health authorities for dialysis services.

Response of Manitoba Health, Seniors and Long-Term Care:

Manitoba Health Seniors and Long-Term Care will incorporate financial analysis of dialysis expenditures along with the outcomes of performance monitoring in its review of funding requests from the regional health authorities and allocation of dialysis funding across the provincial health

system. In collaboration with Shared Health and the Service Delivery Organizations, the department will regularly review patient demand and reallocate existing funding, allowing for more flexible use of existing resources and better meeting the needs of patients and where they live.

Regional Health Authorities including Shared Health are required to submit their operational plans to the department for Ministerial approval, particularly with regard to the funding and human resources implications, along with their achievement of system priorities and goals. The department expects that the regional health authorities will show alignment with the Provincial Kidney Health Plan and integration of the strategic goals into their operational planning.

Appendix A

Dialysis operating expenses by health authority—actuals and funded						
	2021/22		2022/23		2023/24	
Health Authority	Actual dialysis expenses	Funding for dialysis	Actual dialysis expenses	Funding for dialysis	Actual dialysis expenses	Funding for dialysis
Shared Health	38,762,761	34,106,200	37,948,962	34,106,200	38,477,359	34,106,200
WRHA	56,458,021	51,884,575	53,163,370	54,124,275	55,404,536	54,124,275
PMH	10,770,353	9,427,875	10,291,227	9,945,875	10,184,943	12,031,500
IERHA	5,322,366	7,004,950	5,533,216	7,004,950	6,002,965	7,004,950
NRHA	4,516,894	3,956,875	4,551,181	3,956,875	5,062,360	4,050,950
SH-SS	2,807,359	3,164,300	2,700,232	3,164,300	3,559,294	3,164,300

Source: Department funding reports and health authority expense reports - unaudited

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Vision
Government accountability and public administration excellence for Manitobans.

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The Office of the Auditor General of Manitoba acknowledges with respect that we conduct our work on the ancestral lands of Anishinaabeg, Anishininewuk, Dakota Oyate, Denesuline, and Nehethowuk Nations, and on the National Homeland of the Red River Métis. We respect the Treaties that were made on these territories, we acknowledge the harms and mistakes of the past, and we dedicate ourselves to move forward in partnership with Indigenous communities in a spirit of reconciliation and collaboration.

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