REGIONALIZATION OF HEALTH CARE CONTINUES, BC STYLE

An Assessment by the Doctors of BC

A report prepared by the
BCMA Council on Health Economics and Policy

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Regionalization can, on the one hand, offer the flexibility to locate authority and accountability for health care at various levels of government, from central to local, depending on the type of activity and needs of the population...on the other hand...unless appropriately established and implemented, regionalization, particularly decentralization, can lead to a fragmented system plagued with problems of access, mobility, and poorly aligned authorities and accountabilities.

(Canadian Medical Association, 1993)

1.0 Executive Summary

At the end of November 1996, the Minister of Health announced *Better Teamwork, Better Care* as the prescription for health care reorganization in BC. The *Better Care* initiative is based on the report of the Regionalization Assessment Team and is a modified continuation of efforts which began in 1993 as *New Directions*.

The *Better Care* initiative establishes a single layer of governance for each geographic area and reduces the number of Regional Health Boards (RHBs) and Community Health Councils (CHCs) from more than 80 to 45. There will be 11 RHBs in urban areas and 34 CHCs in rural areas. These boards will include 1 physician representative and 1 health care union representative as voting members. All board members will be appointed by the Minister of Health.

Reducing the number of RHBs/CHCs and including practising health care professionals as voting members of the boards is a significant improvement from the *New Directions* approach. However, fully appointed boards inappropriately reduces direct accountability to the public and will entrench the health care system in a hierarchical structure with fewer opportunities for public input. The basis for the number of RHBs/CHCs has not been described, and the actual number of these boards may still be too many for the province. The risk remains of significantly increasing the size of the health care bureaucracy and re-directing scarce health care funds away from direct patient care to administration of this level of governance.

As of April 1, 1997, RHBs received funding for all health care services except provincially-based tertiary care programs, the Medical Services Plan (including physician funding), Pharmacare, and the BC Ambulance Service. For 1997/98, regional funding is based on historical utilization patterns. Possibly as early as 1998/99, government proposes to fund the regions on a “population-needs” basis. Population-based funding is not an exact science. Experience from the UK and the US shows it to be ineffective in predicting future expenditures.

Regional funding places the burden of meeting the health needs of the public on the RHBs/CHCs while defining the budget at the Ministry of Health. Over time, these governing Boards may pressure government to include funds for physician services in the regional funding envelopes. Such an outcome would undermine the cooperative management role of the tri-partite Medical Services Commission (MSC). The governing boards may also pressure government for taxation authority as has occurred in many jurisdictions where regionalization has occurred.

Patient care is threatened. Patients may not be able to receive care outside their home region or from the practitioner of their choice. RHBs/CHCs may feel unable to provide care for sicker patients and attempt to shift these patients to other regions. Balkanization of health care may result, with differences in the health status between “poor” and “wealthy” regions.

Unfortunately, the RAT report and the *Better Care* initiative have not addressed important aspects of health care reorganization. Neither the cost of implementing the change nor the effectiveness of these expenditures to date has been assessed. The importance of establishing a clear and transparent framework to achieve a reduction in unnecessary expenditures has been overlooked.

Effective health care reorganization requires clear objectives to be articulated and a well-defined evaluation process to be implemented. The very important issue of improving integration of health care services has to be addressed as a central component of any proposed new structure. The quality of health care must be maintained at a high level for all citizens of the province in all geographic regions. Health care is still a provincial mandate. There must be a balance between provincial responsibility and the local governing boards.

There has been a continued failure to recognize the importance of medical input in health care reorganization. While the public and governing boards have historically appreciated the value of medical input in assuring the quality of health care, the importance of the medical infrastructure has not been recognized by government and the engineers of health care reorganization. The *Better Care* announcement itself failed in its conclusion that Regional Medical Advisory Committees (RMACs) are not required. Government has delayed the implementation of RMACs for almost 3 years. This is inappropriate. The public wants direct physician input in the health care system and effective health care reorganization requires involvement of the doctors of BC.

2.0 Introduction

This policy position paper provides an overview of the current status of the regionalization of health care in BC with particular emphasis on the changes announced by the Ministry of Health (MOH) in November 1996 as the *Better Teamwork, Better Care* approach. The BCMA Board requested that this paper focus on the implications of the recent changes on the delivery of health care and also address the impact on practising physicians and the BCMA as their member association.

This report builds upon the September 1994 BCMA report, "Regionalization of Health Services in BC". The principle implications of regionalization described in the earlier report continue to apply. This report highlights the effect of changes emanating from the *Better Care* initiative as well as other important outstanding issues of the reorganization of health care governance in BC.

Let us not forget that the purpose is to rationalize our health care system; to apply conscious reasoning to health care reorganization so as to achieve greater efficiency and economy. The alternative of allowing unstated or unexamined motivations to be the foundation of major health reorganization is a recipe for confusion and a very expensive social experiment.

Since the early 1990's, provincial governments across Canada, Ontario being the notable exception, have been pushing to regionalize the governance and funding of health care services (see Appendix C). It is theorized that the establishment of regional governing authorities will both improve the efficiency of health care operations and make the system more responsive to local needs. In 1993, the government of BC began to implement regionalization of health care through the introduction of the *New Directions* initiative. Following the 1996 election, in response to public concerns, the new Minister of Health appointed a team of party MLAs to review the regionalization process, the Regionalization Assessment Team (RAT). In November 1996, the Minister of Health released the report of the RAT and at the same time announced changes to the regionalization process described as the *Better Teamwork, Better Care* approach. The government's *Better Care* initiative is a modification of *New Directions*.

The doctors of BC have continued to demonstrate their commitment to ensuring the health care system in the province is of the highest calibre possible. The BCMA provided input to the 1991 Royal Commission on Health Care, provided input to the government on the *New Directions* initiative, and made a presentation to the RAT in August 1996. A fundamental concern throughout the implementation of reorganization of health care in BC is the exclusion of practising physicians, other professionals, and the public from the process. To successfully implement a regionalized system of health care, the input of these groups is critical. The training and experience of physicians provides the fundamental knowledge of health needs and effective treatments which are essential to any reorganization of health care.

3.0 History of Regionalization in BC

3.1 Government's Stated Reasons For Regionalizing Health Care

In 1993, the Ministry of Health introduced *New Directions* and stated five primary reasons for regionalization of health care in BC:

1. better health through increased health promotion and prevention of injury and illness;

2. greater public participation and responsibility;

3. bringing health closer to home with more services in people's homes, local communities, and regions;

4. respecting the care provider by ensuring pay equity and a safe working environment;

5. effective management with increased emphasis on accountability and the more efficient use of health care resources.

3.2 1996 Review Of Regionalization

In response to professional and public concern about *New Directions*, BC Health Minister Joy MacPhail appointed a team of party MLAs, the Regionalization Assessment Team (RAT), to provide a candid assessment of the strengths and weaknesses of the existing regionalization process. It was her stated goal to assure the public that regionalization was managing the health system better so that more dollars are spent on direct patient care and less are spent on bureaucracy, waste and duplication. Minister MacPhail said, ". . . it would be irresponsible to ignore areas of genuine concern. As a new Minister responsible for health issues, I simply was not prepared to proceed with major changes in health care until I fully understood and assessed all the implications of regionalization". The terms of reference for the RAT emphasized the need to review the cost-effectiveness of regionalization.

3.3 Changes From *New Directions*

In November 1996, the Minister of Health unveiled *Better Teamwork, Better Care.* Government highlighted the following key changes from *New Directions*:

1. A single layer of governance in each geographic area: Regional Health Boards (RHBs) in urban areas, Community Health Councils (CHCs) in rural areas;

2. Reduction in the number of RHBs & CHCs: The number of RHBs are reduced from 20 to 11 and the number of CHCs are reduced from 82 to 34.

3. The size of boards will be limited: RHBs and CHCs will have 15 members (18 in the Vancouver/Richmond region); and the Minister may appoint 3 additional members at her discretion.

4. Fully appointed boards: All board members will be appointed by the Minister.

5. Health care providers on RHBs & CHCs: one physician and one health care union representative will be voting members of each RHB/CHC;

6. Mandated Performance Guidelines: each RHB/CHC will be required to sign a contract with the Ministry that defines performance guidelines reflecting the government's priorities for health.

In addition to these six highlighted changes, the *Better Care* initiative includes several other significant changes:

7. RHBs will no longer be required to establish specific advisory committees such as the Regional Medical Advisory Committee, Union Management Committee, and Health Service Providers Advisory Committee.

8. RHBs will eventually receive population-based funding for all services in the region and will provide a platform for other important health care initiatives such as management of physician resources.

9. The Ministry of Health (MOH) will withdraw entirely from the direct provision of health care services but will continue to manage some services such as the Medical Services Plan, the BC Ambulance Service, and Pharmacare.

10. The *Better Care* initiative also described the potential relationship of the MOH with the budding Ministry for Children and Families. Over time the MOH will share joint funding of public and community health programs currently in place with the new Ministry and the new Ministry will assume responsibility for alcohol and drug workers, and employees in the area of child and youth mental health services currently employed by the MOH.

4.0 The Implications of *Better Teamwork, Better Care*

The government's *Better Teamwork, Better Care* initiative is a modified continuation of regionalization. It is not a new health care initiative. The report of the Regionalization Assessment Team (RAT) does not provide sufficient evaluation of the process to date and leaves many questions unanswered.

The implications of regionalization have been divided into several broad categories to assist in understanding the current health care reorganization in BC. These broad categories are:

ACCOUNTABILITY
GOVERNANCE
REGIONAL FUNDING
MEDICAL INPUT

4.1 Accountability

A major tenet of health care reform stated by the Royal Commission in the 1991 "Closer To Home" report and included in *New Directions* is the need for improved efficiencies through greater accountability and reduced bureaucracy. To ensure accountability, one requires a credible evaluation process.

4.1.1 The Evaluation Process

The BC government's stated reasons for *New Directions* and for regionalizing health care delivery and governance are general philosophies, not clear goals and objectives for reorganization of health care. System-oriented goals have never been provided.

As stated in "A Framework for Evaluating Devolution", prepared for the Ontario Premier's Council on Health, Well-Being and Social Justice in 1994, evaluating the effectiveness of change requires adoption of a process that includes the following components:

- clearly defining the objectives at the start,
- asking what questions need to be answered to determine if the objectives are achieved or not,
- examining the questions to determine if they are measurable and what data will need to be collected, and
- evaluating the resulting data (Premier's Council, 1994).

These components for effective evaluation are inseparable and eliminating any one of them will render the process ineffective. Health care reorganization in BC has not included the five components required to establish a proper evaluation process. The report of the government's Regionalization Assessment Team (RAT) does not provide a sufficient evaluation of the process to date and leaves many questions unanswered.

The BCMA reiterates the following recommendations from its 1994 policy position paper, Regionalization of Health Services in BC:

RECOMMENDATION #1

The objectives of health reform in BC must be clearly stated.

A well-defined evaluation process must be implemented.

The Ministry of Health must commit to a formal, external evaluation of the effectiveness of regional governance at regular intervals. This process must be explicitly identified as soon as possible and adequate government funds made available.

An independent Provincial Health Council should be established by the Ministry of Health to objectively analyze the health status of BC and provide a yearly "report card".

4.1.2 Defining Health

New Directions specifically identified the World Health Organization (WHO) definition of health as the definition upon which health care reorganization is to be based. The *Better Care* approach is silent on this issue. It is presumed, therefore, that adherence to the WHO definition continues.

The adoption of such a broad definition of health that includes all physical, psychological, social and spiritual needs, is a significant departure from the definition of health care that formed the basis of Canada's Medicare system, as included in the *Canada Health Act (1984)*. This "everything for everyone" approach is a potentially costly departure from the earlier, successful models of publicly funded health care in Canada.

As described by Justice Emmett Hall, the Canada Health Act was based on providing necessary medical care to all Canadians; to ensure people receive required medical care without catastrophic financial burden.

RECOMMENDATION #2

The broad definition of health care adopted by New Directions is beyond the capacity and expectation of a publicly funded health care program. This definition must be refocussed to ensure a sustainable, publicly funded health care system in BC.

4.1.3 Defining Core Services

The BCMA continues to believe that defining core services and standards is an essential undertaking, especially with the current pressures on limited resources for health care. Explicit delineation of those services that will be provided through the public program is essential. Within this process, it is imperative to distinguish between core health and core medical services. The BC government's November 1995 draft list of core health services is non-specific and insufficient. There has been little progress in defining core services and the *Better Care* approach does not identify a process that will be undertaken to achieve this. It is imperative to distinguish between core health and core medical services.

The BCMA reiterates the following recommendations from its 1994 policy position paper Regionalization of Health Services in BC:

RECOMMENDATION #3

Core services and standards development is an important subject as it embodies assurance to the public that essential health services will be maintained.

The existing government definition of core health and medical services and standards is insufficient and requires considerable refining, including consultation with the medical profession.

Input from physicians and other health care professionals is critical in the development of core health services to ensure that acute care services are maintained at acceptable levels and changes to existing programs are instituted on evidence-based evaluation of the costs and benefits. The BCMA requests more formal participation in the drafting of core health services and standards for BC.

Government must work cooperatively with health care providers and the public to define core medical services for the province.

Each region must be held accountable for providing, at minimum, all provincially defined core services.

4.1.4 Health Objectives

The doctors of BC are committed to improving the health status of the people of British Columbia and believe this requires examining strategies employed throughout the health care system. This involves the full range from maintaining health; preventing illness and injury; providing screening, early diagnosis, and preventing complications of illness; effective treatment of acute and chronic illness; palliative care; care of the disabled and elderly.

On a daily basis, physicians provide patient care and education to help people avoid problems prior to illness, reduce exacerbations and avoid complications. Further emphasis on employing proven preventive strategies will help to reduce the burden of illness in the population. Patients also seek assistance from their physician when attempting to improve their health through life style changes such as smoking cessation, improving nutrition and weight reduction. While these strategies have proven value, the Medical Services Plan does not include allowance for these to be provided as an insured benefit.

Care of the chronically ill and elderly requires ensuring resources are appropriately applied to home services and extended care facilities. The transfer of resources from acute care facilities must be linked to the actual transfer of services. Reductions in resources to acute care facilities without transferring of services results in additional demands on emergency departments and physicians offices and results in longer waiting lists for necessary treatments.

4.1.5 Fiscal Responsibility

The terms of reference for the Regionalization Assessment Team emphasized the need to review the cost-effectiveness of regionalization. Unfortunately, the report provides very few details on this important subject. The report states that reducing the number of governing bodies will result in reduced administration costs and opportunities for more cost-effective integration of care. Some presentations to the RAT indicated that integration of services would have happened without the creation of new governance structures. Specific details on the cost-effectiveness of regionalization are not provided in the report and there are warnings of additional costs that will be incurred related to severance payouts. The RAT report recommends "more emphasis be put on developing and articulating clear strategies for reducing unnecessary health expenditures" but does not provide a framework to achieve this.

It is difficult to clearly understand the cost of the health care system. Revenues include transfers from the federal government, MSP premiums, funds from general provincial taxation, lottery funds, municipal contributions to capital expenditures, community fundraising and hospital lotteries. Likewise, expenditures occur at a variety of levels and through a variety of programs. In November 1994, the then Minister of Health, the Honourable Paul Ramsey, stated in a speech at the Vancouver Trade & Convention Centre that government was supporting the existing health system "with a billion dollar increase in annual health spending in the three years since this government came into office". The annual budget for the Ministry of Health increased from $6.00B to $6.94B between 1992/93 and 1996/97, an increase of almost 16%. Neither the RAT report nor the Ministry of Health have provided details as to where these increased funds have gone. During this same time period, we have witnessed a deterioration in health care services. This is demonstrated by cutbacks, bed shortages, emergency departments bursting at the seams, and increased waiting lists. The 1997 Fraser Institute Waiting List Report indicates that BC's waiting lists have grown significantly over the past year and government has announced the need for further expenditures to reduce waitlists this year (Ramsey & Walker, 1996). Furthermore, $30 million was spent exclusively on promoting *New Directions*. The effectiveness of this has not been formally assessed. A 1995 survey demonstrated that, with respect to the effectiveness of *New Directions* and communication of the plan, Ministry of Health officials

felt they had done an acceptable to above average job while the majority of hospital participants rated the government's performance as "poor" or "very poor" (Azad, 1995).

Additional expenses are inevitable with the proposed health care reorganization. Government recently restated that $8 million in transition funding was budgeted in the 1996/97 fiscal year and the final payment of this was scheduled to be distributed on January 1, 1997. CHCs that remain in the planning stages will be eligible for additional transition funding in the next fiscal year to help them prepare for the transfer of authority.

RECOMMENDATION #4

Regular reporting of the costs of Ministry of Health programs and regional governance must be made publicly available.

There must be transparency in RHB/CHC spending, open to professional and public scrutiny.

4.1.6 Bureaucracy & Administration

It is not at all clear that *New Directions* achieved any reduction in the size of the health care bureaucracy. The RAT report does not address this issue. Neither the RAT report nor the *Better Care* initiative provide a clear process for achieving a reduction in the bureaucracy. The Ministry of Health has announced plans to shift more than 3,000 employees to the regions over the next 2 years. Reductions in administration and bureaucracy must be based on real reductions and not simply on eliminating vacant positions or transferring staff to other positions.

The BCMA believes the current approach to regionalization in BC will inappropriately redirect scarce health care dollars from patient services to administration. There is a great deal of evidence from Europe and New Zealand that regionalization of health care services greatly increases the size of the health care bureaucracy. In times of increasingly scarce health care dollars, such an outcome is entirely inappropriate. A significant portion of the difference in health care spending between the USA and Canada today is directly due to the much lower costs of health care administration in this country. Moving funding and administrative responsibilities to the regional and community level, together with hiring the administrative expertise which each region will require, may well offset any potential cost savings in health service delivery. In addition, the potential exists for a lack of appropriate administrative skills and expertise at the local level. This will ultimately compromise the quality and efficiency of the health care system. As the regions' range of responsibility broadens, so too do the resources required to enable these units to exercise their authority effectively. Already, we have seen examples of large severance packages to rearrange the administrative "deck chairs" in some regions.

RECOMMENDATION #5

The government of BC must ensure that the health care bureaucracy is reduced and not simply moved to support another level of governance.

4.2 Governance

Reorganization of the governance of health care should be based on clearly stated principles and objectives.

Health care is a provincial mandate and as such the Minister of Health should retain responsibility, authority and accountability for the quality of health care. The governance structure should not allow the Minister to abdicate this role and deflect responsibility to other levels of governance. It is equally important that the quality of health care is uniform throughout the province and does not become balkanized.

Local input is also required to improve the understanding of the health needs of the population, barriers impeding access to health care services in different parts of the province and ways to improve the integration of services needed throughout the province. It is debatable whether it is better for local input to be through an advisory structure or one with full authority. Regardless, having made a decision on the structure for local input, government must ensure the principles and objectives of governance are met.

4.2.1 Single Layer of Governance

Regional Health Boards (RHBs) and Community Health Councils (CHCs) have a much broader scope of responsibility than just hospitals, as many perceive. They will govern all of the community services which the Ministry of Health has traditionally been responsible for. Board scope includes acute care, continuing care, mental health, public health, alcohol and drug, and aboriginal health. As of April 1, 1997, RHBs received financial authority. They now fund hospitals, public health departments, and community care programs. Over the next year, government intends to pass full fiscal accountability onto the RHBs.

As compared to *New Directions*, a single layer of governance in each region/community below the provincial government may reduce confusion and help clarify the Board's role. This should streamline health care delivery. Patients and providers will be able to deal with a governing body responsible for a broad spectrum of health care. However, this does not address the major challenge for many rural communities which has been the need for better integration of health services. While some of these communities felt they were making headway on the issue of integrating health services, the recent *Better Care* changes shift the focus to autonomous CHCs. This may result in a re-emergence of rivalries between adjacent areas and a fragmentation of service delivery.

There is little incentive for RHBs and CHCs to look at the impact of decisions beyond their area. This may significantly hinder the overall efficiency of the system. Both urban and rural governance structures must focus on the integration of health care services.

It is reassuring that the *Better Care* initiative has reduced the number of RHBs & CHCs, however, the basis upon which the number of governing bodies was determined is not clear. Even 45 Boards (11 RHBs/34 CHCs) may be too many for a province with a population no larger than metropolitan Toronto, Montreal, or many American cities.

New Zealand, a country with a population roughly equivalent to BC, and with similar geographic characteristics, originally established 14 Area Health Boards (AHBs). In 1993, these 14 AHBs were replaced with only 4 Regional Health Authorities (RHAs), each serving a population ranging from 650,000 to 1,100,000. Health Maintenance Organizations (HMOs) in the United States require even larger populations to achieve maximal economies of scale. It is interesting to note that, while the BC government has implemented 11 RHBs and 34 CHCs, the Ministry of Health has been re-aligned into only 5 regional support teams to enable this transfer. Additional savings may be realized by further reducing the number of RHBs/CHCs and the support each will require.

The BCMA is not convinced that abolishing hospital boards will lead to improved service delivery. Regional hospitals are very complex organizations and a single RHB may not be able to effectively manage multiple regional hospitals. The action of disbanding volunteer boards throughout the province does not, in itself, assure improved efficiencies. This widespread action may result in the loss of management expertise at the local level. Furthermore, auxiliary organizations associated with facilities may cease to exist. Volunteer societies may find the newly formed RHBs and CHCs less responsive to the needs of their communities.

A significant proportion of health funding will go towards the operation of RHBs and CHCs. Therefore, it is important to have a sound basis for the number of these boards throughout the Province. It is also important to clearly identify the relationships between RHBs/CHCs and hospitals and how these new governance structures will enhance the functioning of hospitals.

The BCMA re-iterates the following recommendations from its 1994 policy position paper Regionalization of Health Services in BC:

RECOMMENDATION #6

There are too many RHBs and CHCs in BC. Government must work to consolidate existing RHBs and CHCs to reduce unnecessary duplication.

Boundaries for health, education, and social services should be coterminous wherever possible.

The BCMA adds the following recommendations:

RECOMMENDATION #7

The BCMA supports a single layer of health care governance at the region/community level.

RECOMMENDATION #8

The Minister of Health must clarify the relationship between the hospital boards of Vancouver, Nanaimo, Kamloops, Kelowna, and Prince George and the RHBs.

4.2.2 Fully Appointed Boards

Through the *Better Care* initiative, all RHBs/CHCs are fully appointed with no elected members. Appointed boards represent the wishes of the Minister of Health, not the local community. This allows the provincial government to deflect responsibility to a non-elected, non-representative governing body while still controlling its agenda. Fully appointed Boards will also entrench the health care system in a hierarchical structure, further empower CEO's and may provide fewer opportunities for local input.

The Auditor General's recent comments regarding appointments to boards of Crown Corporations may be equally applicable to government appointments of other Boards such as RHBs and CHCs. The Auditor General emphasized that a legitimate process is needed. "The starting point for an effective board is an appointment process that can demonstrate that government has: identified the skills, experience, and other attributes required of board members; sought expressions of interest for those positions; evaluated applications against objective criteria; and selected from the applicants the person most likely to be an effective member of the board." At the federal level, the Veilleux Report (March 1994) recommended more objectivity and transparency in the appointment process. ". . . that the primary criterion for selection of candidates be proven relevant experience" and "that appointees represent the communities they serve" (BC Auditor General, 1996).

RECOMMENDATION #9

Fully appointed boards inappropriately reduce direct accountability to the local public and increase the power of bureaucrats and administrators staffing the Regions.

The members of RHBs and CHCs should be elected, not fully appointed.

4.2.3 Role of Physician Representatives on RHBs and CHCs

Better Care includes an appointed physician representative on each RHB & CHC. This is a significant improvement from the *New Directions* approach. The Minister of Health announced that physicians would be called upon to help design the process for these appointments. In January 1997, the Minister of Health requested physician nominees from several sources including the BC Medical Association, BC Cancer Agency, BC College of Family Physicians, Chinese-Canadian Medical Society, College of Physicians and Surgeons of BC, Federation of Medical Women of Canada - BC Chapter, PAR-BC, UBC Faculty of Medicine, and WCB.

RECOMMENDATION #10

It is the role of the physician representative to the RHB/CHC to:

- *be a patient advocate at the Board.*
- *provide the medical perspective on deliberations of the Board;*
- *enhance the Board's receptivity to medical input;*
- *liaise with the RMAC and physician bodies within the region/community; and*
- *represent practising physician interests within the region/community;*

The physician nominee to each RHB must be elected by the local medical community.

4.3 Regional Funding

The BC government proposes to allocate more than $3.0 B, approximately 50% of the total health budget, to the RHBs and CHCs. This does not include funds for provincial-based tertiary care programs, the Medical Services Plan (which includes physician funding), Pharmacare, and the British Columbia Ambulance Service. Minister of Health, the Honourable Joy MacPhail, has stated that, "with few exceptions, the Ministry of Health will withdraw entirely from the direct provision of health care services". RHBs "will eventually receive population-based budgets for all services in the region . . . RHBs will provide a platform for other important health care initiatives such as management of physician resources".

Government's stated goal for regional funding envelopes is to "facilitate reduction in health status inequities across regions through equitable allocation of funds to Regional Health Boards". A draft regional funding formula has been prepared by the Ministry of Health. It includes the following principles: that allocations must be in proportion to regional needs, must be simple, consistent, transparent, and resistant to manipulations.

The Ministry's draft regional funding formula is essentially a population-based capitation approach. Regional "needs" are dependent upon population size and structure, as well as social, economic and environmental factors. Although initially regional funding will be based upon historical utilization patterns, government is working towards introducing a needs-based formula for the 1998/99 or 1999/2000 fiscal year. Government has also indicated the possible move to allocating the budgets for physician and Pharmacare services to the regions.

Regional funding may further threaten patient choice. Will patients still be able to move across regions for medical care? Will facilities with limited budgets accept patients outside their jurisdiction? Regions may feel constrained to stay within their budgets and expect sicker patients to receive care in other regions. This may create disparities in the quality of care between "rich" and "poor" regions.

Since the RHBs/CHCs will be dependent on receiving funds from the provincial government in Victoria, but still responsible for the provision of health services, there is a distinct risk that Boards may petition for and receive taxation authority in the future. An additional level of taxation is not favoured by the public but may become an inevitable consequence of regionalization. Experience from Europe, and the framework of the existing BC legislation, make local taxation for health care a very real possibility.

To a large degree, existing government policy on regionalized medical services budgets is based upon the recommendations contained within a 1988 article written by Dr. Robert Evans of the University of British Columbia, entitled "Squaring the Circle". Dr. Evans proposes the development of a regional budget model as a refinement to the provincial budget for health care services. His model is based on payments for services to residents rather than payments to providers (Evans, 1988), taking into account their age/gender mix and other health need determinants. Cost overruns are borne by each region. Clearly, this represents a major shift from the existing funding arrangement.

Population-based funding and risk adjustment are not exact sciences. They are very subjective. Even after many years of experience, the United Kingdom still determines its regional and general practitioner funding envelopes on the basis of historical utilization patterns rather than population-based indices. They have found a "population-based" approach to be practically unattainable. Similarly, numerous American health care purchasers are returning to a historic utilization basis for funding services after failing to adequately predict expenditure through 'population-based' approaches. Furthermore, allocating funds on the basis of population demographics does not ensure the integration of delivery of health care services. Allocation of funds should be done in a manner that enhances the integration of health care delivery.

It is imperative that if some other construct such as population-based funding is to be applied to the allocation of health care resources the construct should first undergo a critical evaluation.

RECOMMENDATION #11

Government must obtain public and provider feedback before finalizing its population-based funding formula.

Global regional budgets must not impede cross-regional utilization based upon patient need.

The MSP fee-for-service physician budget must continue to be held and negotiated provincially.

Fee-for-service payments should be used for direct patient care and not for subsidizing administration, teaching, or research.

4.4 Medical Input

Physicians carry a considerable amount of responsibility in the health care system. There is an identifiable physician responsible for the care each patient receives in acute and extended care facilities. Physicians actively participate on many committees to ensure quality of care improvement and standards. In these ways, physicians protect the public interest and provide reassurance to the public on the quality of their health care system. Surveys have borne out the fact that the public want physician input in health care reorganization.

While the responsibility of physicians for patient care remains high, the level of physician input into planning and management has been reduced. Some senior managers and CEO's prefer to select the medical input to better suit their management style and have been resistant to joint reporting to themselves and the governing board. Others have attempted to minimize the importance of physician input by considering it to only represent physician self-interest. This runs contrary to historical experience through which governing health care boards have worked closely with physicians. Board members have appreciated direct input from physicians to help them understand important health issues. Physicians have traditionally found board members very receptive to direct medical input and structures such as Joint Conference Committees have existed because they serve a very useful function.

The BCMA has continued to support strongly its members' activities at the local planning level even though the reform process has discriminated against active physician participation. Doctors have been intentionally left out of the process and repeatedly told that their opinion is not needed nor wanted. Consequently, planning decisions have been disproportionately influenced by the non-medical community.

The BC health care system has been subject to major changes by politicians and Ministry of Health personnel whose training is largely focused on sociology, political science, or public administration and whose work experience has been fragmented by frequent turnovers in assignments with limited continuity. Such a background of training and experience may account for the perception that Ministry of Health officials lack a realistic understanding of the issues and challenges associated with hospital and financial operations (Azad, 1995).

As described by one of the Board members of the BCMA, “mutual respect goes a long way when we face difficult times . . . however . . . the process that is presently in place to implement regionalization is eroding the working relationship we have worked so long to establish”.

4.4.1 Regional Medical Advisory Committees

The importance of medical input at the various levels of the health care system is obviously not apparent to the engineers of health care reorganization in BC. The establishment of Regional Medical Advisory Committees has been delayed since the spring of 1994 by the inaction of government. *Better Care* further demonstrated the lack of consideration for the importance of the infrastructure for medical input when it was announced that RMACs would no longer be required. Even though government has since recognized that RMACs are required, the statements originally made have delayed implementation of RMACs in many regions.

The infrastructure for medical input must not be dismantled through the process of health care reorganization. Effective reorganization must include appropriate additions to the infrastructure for medical input . The BCMA’s attempts to establish Regional Medical Advisory Committees (RMACs), with terms of reference that embody principles of accountability through a democratic process, have met with opposition from government. A fully functioning MAC is critical for the successful administration of the bylaws and also for assuring a number of important quality improvement and utilization management activities.

RECOMMENDATION #12

It is imperative that Medical Advisory Committees be fully functioning for each RHB and CHC. MAC representatives must be elected by locally practising physicians.

RMACs must report directly to the RHB/CHC.

The BCMA should forward, as soon as possible, its most recent version of RMAC terms of reference to all BCMA Local Action Committee representatives (LACs), all RHB/CHC chairs, and all Regional Medical Society Presidents.

4.4.2 Physician Resource Planning

Since 1993, BC has had a tripartite Medical Services Commission (MSC) responsible for administering the Medical Services Plan. The MSC is responsible for numerous activities including utilization review and physician supply management.

RECOMMENDATION #13

The tripartite MSC is a critical resource for managing medical issues in BC.

Management of physician resources should remain a provincial responsibility through the MSC, including regional and medical input. RMACs and the BCMA Sections should be an integral component of the feedback process.

5.0 Summary of Recommendations

The Evaluation Process

RECOMMENDATION #1

The objectives of health reform in BC must be clearly stated.

A well-defined evaluation process must be implemented.

The Ministry of Health must commit to a formal, external evaluation of the effectiveness of regional governance at regular intervals. This process must be explicitly identified as soon as possible and adequate government funds made available.

An independent Provincial Health Council should be established by the Ministry of Health to objectively analyze the health status of BC and provide a yearly "report card".

Defining Health

RECOMMENDATION #2

The broad definition of health care adopted by New Directions is beyond the capacity and expectation of a publicly funded health care program. This definition must be refocussed to ensure a sustainable, publicly funded health care system in BC.

Defining Core Services

RECOMMENDATION #3

Core services and standards development is an important subject as it embodies assurance to the public that essential health services will be maintained.

The existing government definition of core health and medical services and standards is insufficient and requires considerable refining, including consultation with the medical profession.

Input from physicians and other health care professionals is critical in the development of core health services to ensure that acute care services are maintained at acceptable levels and changes to existing programs are instituted on evidence-based evaluation of the costs and benefits. The BCMA requests more formal participation in the drafting of core health services and standards for BC.

Government must work cooperatively with health care providers and the public to define core medical services for the province.

Each region must be held accountable for providing, at minimum, all provincially defined core services.

Fiscal Responsibility

RECOMMENDATION #4

Regular reporting of the costs of Ministry of Health programs and regional governance must be made publicly available.

There must be transparency in RHB/CHC spending, open to professional and public scrutiny.

Bureaucracy & Administration

RECOMMENDATION #5

The government of BC must ensure that the health care bureaucracy is reduced and not simply moved to support another level of governance.

Single Layer of Governance

RECOMMENDATION #6

There are too many RHBs and CHCs in BC. Government must work to consolidate existing RHBs and CHCs to reduce unnecessary duplication.

Boundaries for health, education, and social services should be coterminous wherever possible.

RECOMMENDATION #7

The BCMA supports a single layer of health care governance at the region/community level.

RECOMMENDATION #8

The Minister of Health must clarify the relationship between the hospital boards of Vancouver, Nanaimo, Kamloops, Kelowna, and Prince George and the RHBs.

Fully Appointed Boards

RECOMMENDATION #9

Fully appointed boards inappropriately reduce direct accountability to the local public and increase the power of bureaucrats and administrators staffing the Regions.

The members of RHBs and CHCs should be elected, not fully appointed.

Role of Physician Representatives on RHBs and CHCs

RECOMMENDATION #10

It is the role of the physician representative to the RHB/CHC to:

- *be a patient advocate at the Board.*
- *provide the medical perspective on deliberations of the Board;*
- *enhance the Board's receptivity to medical input;*
- *liaise with the RMAC and physician bodies within the region/community; and*
- *represent practising physician interests within the region/community;*

The physician nominee to each RHB must be elected by the local medical community.

Regional Funding

RECOMMENDATION #11

Government must obtain public and provider feedback before finalizing its population-based funding formula.

Global regional budgets must not impede cross-regional utilization based upon patient need.

The MSP fee-for-service physician budget must continue to be held and negotiated provincially.

Fee-for-service payments should be used for direct patient care and not for subsidizing administration, teaching, or research.

Regional Medical Advisory Committees

RECOMMENDATION #12

It is imperative that Medical Advisory Committees be fully functioning for each RHB and CHC. MAC representatives must be elected by locally practising physicians.

RMACs must report directly to the RHB/CHC.

The BCMA should forward, as soon as possible, its most recent version of RMAC terms of reference to all BCMA Local Action Committee representatives (LACs), all RHB/CHC chairs, and all Regional Medical Society Presidents.

Physician Resource Planning

RECOMMENDATION #13

The tripartite MSC is a critical resource for managing medical issues in BC.

Management of physician resources should remain a provincial responsibility through the MSC, including regional and medical input. RMACs and the BCMA Sections should be an integral component of the feedback process.

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APPENDIX A: *Better Teamwork, Better Care* - What's Changed, What Won't Change

The Better Care Approach to Regionalization: On November 28, 1996 Health Minister Joy MacPhail introduced the "Better Care" approach to regionalization. The simpler, streamlined version will ensure the government meets its top priority of providing better care and better health services for all British Columbians.

What's Changed?

- ***Number of RHBs/CHCs Reduced***: We've cut the number of Regional Health Boards and Community Health Councils by more than half, from 102 to 45.

  New Directions: 20 Regional Health Boards / 82 Community Health Councils
  Better Care Approach: 11 Regional Health Boards retained around major urban centres / 34 CHCs retained in rural/geographically isolated areas.

  Why? Fewer boards equals better service integration and more opportunities to reduce waste, duplication and bureaucracy.

- ***Single Layer of Governance***: A single layer of health care management and governance will be in place below the Ministry of Health across the province.

  New Directions: Some communities housing both a CHC and RHB leading to expansion, not reduction of bureaucracy and confusion over roles.
  Better Care Approach: No CHCs within boundaries of 11 RHBs. No RHBs overseeing actions of 34 CHCs retained in rural areas.

  Why? Clearer roles and responsibilities for both RHBs and CHCs will reduce waste and bureaucracy, and eliminate confusion over jurisdiction.

- ***Size of Boards Reduced***: Limits will be imposed on the size of RHBs/CHCs.

  New Directions: No defined limit of RHB/CHC board size.
  Better Care Approach: 15 member boards. (18 in Vancouver to reflect unique role in delivery of specialized services) Boards to reflect population & diversity of region/community. Minister to have ability to appoint 3 additional members at her discretion where population mix or size warrants.

  Why? Smaller boards designed to achieve more effective decision-making. Also more cost-effective, easier to convene and require fewer members to achieve a quorum.

- ***Fully Appointed Boards***: All board members appointed by the Minister. In the long-term, appointments will be based on a local nomination process, followed by non-partisan review of potential nominees.

  New Directions: CHCs - 2/3 elected, 1/2 appointed; RHBs - 2/3 CHC members, 1/3 appointed
  Better Care Approach: CHCs & RHBs fully appointed

Why? To place health care decision-making in the hands of people reflecting a broad range of skills, interests and experience within the communities and regions they serve. This was not necessarily being achieved in the New Directions model.

- ***Health Care Providers on RHBs & CHCs***: Two health care providers appointed as voting members of each RHB/CHC - one physician and one health care union representative.

  New Directions: Each RHB/CHC required to develop three formal advisory committees comprised of doctors and other health providers. No doctors as voting members.
  Better Care Approach: Advisory committees no longer mandated. Interests of health care providers incorporated through the appointment of a doctor and a health care union representative on the RHBs/CHCs.

  Why? To respond to health providers concerns during the assessment of New Directions and ensure the expertise and input of those on the front lines of our health care system is reflected on the RHBs/CHCs.

- ***Mandated Performance Guidelines***: Each RHB/CHC to sign a service contract with the Ministry, that defines measurable performance guidelines, reflecting the government's priorities for health.

  New Directions: No specific management contract, defining standards of appropriate care. No audits or annual reports of RHB/CHC performance.
  Better Care Approach: Quality and accessibility of patient care to be defined in a management contract covering areas such as waiting time for treatment, readmission rates, lengths of stay and patient satisfaction. Results to be tracked and audited by Ministry.

  Why? To guide the new regions and councils as they embark on their new roles and ensure high standards of patient service and health care quality are maintained across the province.

WHAT WON'T CHANGE

- ***Regional Hospital Districts*** - Current boundaries and mandate to remain intact. Locally elected officials will continue to have taxation authority for new capital health projects.
- ***Vancouver Cluster Boards*** - No change in current composition of governance structure for acute care and rehabilitation services in Vancouver. Provincial and highly specialized programs and services in Vancouver hospitals to be monitored by Ministry.
- ***Volunteer Involvement*** - Volunteers will continue to have a vital role in the health care system, through fund-raising/auxiliary activity.
- ***Provincial Access to Tertiary Services*** - All British Columbians will continue to have access to specialized acute services.
- ***Plans to transfer Ministry staff*** - Government will proceed with its original plan to devolve Ministry staff to new regional authorities.
- ***Minister's Role*** - The Minister will continue to hold ultimate accountability for our health care system, ensuring the principles of Medicare are upheld and that British Columbians continue to enjoy access to high quality health services, regardless of where they live.

APPENDIX B: Recommendations Of The Regionalization Assessment Team - As Addressed By *Better Teamwork, Better Care*

RAT: We recommend responsibility for the health care system not be the same in all regions of the province.

BTBC: RHBs will be retained in areas of the province where the population is generally concentrated in large communities in close geographic proximity to one another. Regions require a population base large enough to support a broad range of health services, including a referral hospital and other specialty programs.

CHCs will be retained in areas where there are small population centres in geographically isolated communities and a more narrow range of services provided.

RAT: We recommend the implementation of different governance approaches in rural and urban areas.

BTBC: The need for different approaches in rural and urban areas of the province will be recognized.

RAT: We recommend the Ministry of Health assess the readiness of Boards and Councils to assume responsibility for health care services on a case-by-case basis and establish timelines for devolution of responsibility to match the readiness of the Board or Council.

BTBC: It is expected that all of the RHBs and some of the CHCs will be ready to assume authority by April 1, 1997. The remainder are expected to assume authority no later than October 1, 1997. Before authority for services is transferred, boards and councils will have to demonstrate success in amalgamating health care services. In addition, their management capability must be assessed by a Ministry review team to ensure there is no disruption in service and that the transition itself is as smooth as possible. Each RHB/CHC will also have to adopt appropriate bylaws and, where applicable, ensure their community/ regional health plan is consistent with new boundaries. 5 regional work teams from the Ministry (Thompson / Okanagan / Kootenays, Vancouver / Richmond / Burnaby / Simon Fraser, the North, Fraser Valley, Vancouver Island / Sunshine Coast / North Shore) have been assigned to help RHBs/CHCs prepare for the transfer process.

RAT: We recommend a strategic approach to responsibility for Aboriginal health services be developed in partnership with Aboriginal communities and with the federal government, where appropriate. The current funding arrangements between the Ministry of Health and Aboriginal service providers should continue unless the affected Aboriginal communities agree otherwise.

BTBC: There will be no mandated Aboriginal representation on the boards and councils. However, as part of the appointment process, the Minister will consider the demographics of particular regions and communities in selecting representatives to sit on the RHBs/CHCs. RHBs and CHCs have also been asked to address the needs of designated populations in their health and management plans.

RAT: We recommend Regional Health Boards and Community Health Councils not exist in the same areas of the province. That is, there should not be a two-tier system of governance.

BTBC: Under the *Better Teamwork, Better Care* approach, there are no CHCs within the boundaries of the 11 RHBs and no RHBs oversee the actions of the 34 CHCs in the rural areas.

RAT: We recommend that if the number of governance bodies are reduced, steps be taken to ensure related costs are kept at a minimum and attempts are made to place affected personnel in vacant positions where this is feasible.

BTBC: The government is proceeding with its plan to devolve Ministry staff to new regional authorities.

RAT: We recommend there be no elections to RHBs or CHCs.

BTBC: Under *Better Teamwork, Better Care,* all boards members are appointed by the Minister, and in the long term will be appointed based on a local nomination process, including a non-partisan review of potential nominees.

RAT: We recommend there be no remuneration for individuals who sit on RHBs or CHCs.

BTBC: Board and council members will be compensated for expenses such as travelling, dependent care, and wage reimbursement.

RAT: We recommend the Minister reconsider the number of Regional Health Boards in the Lower Mainland and determine if further amalgamation could result in greater integration of services and further efficiencies.

BTBC: The Vancouver Regional Health Board and the Richmond Regional Health Board have been merged to form a single regional health board. The Simon Fraser Region and Burnaby Region have also been merged to form a single region.

RAT: We recommend the Minister reconsider on a case-by-case basis the current CHCs to determine whether the CHC boundaries are appropriate and to determine whether some CHCs should be amalgamated with neighbouring CHCs or integrated into an adjacent region. Any decisions to change boundaries should be informed by an analysis of the relevant patient referral patterns.

BTBC: The number of Regional Health Boards and Community Health Councils was cut from 102 to 45. Under *Better Teamwork, Better Care*, there are 11 RHBs and 34 CHCs.

RAT: We recommend more emphasis be put on developing and articulating clear strategies for reducing unnecessary health expenditures.

BTBC:
Part of the RHBs' mandate is to:
- achieve significant cost savings through consolidation and rationalization of services and economies of scale
- ensure a continuum of care for patients through better integration of community and institutional services in major urban regions
- provide a platform for other important health care initiatives such as management of physician resources

CHCs will aim to:
- find efficiencies and savings which can be used to improve local patient services
- allow local input into the delivery and management of health care services

RAT: We recommend the Minister consider providing physicians and unionized health care providers a vote on the governing bodies of the regional health care authorities.

BTBC: Each of the RHBs/CHCs will be composed of up to 15 members, with one seat reserved for a physician and one seat reserved for a health care union representative. The Vancouver Board will have 18 members to reflect the unique specialized acute services it will manage. Initially, the two seats set aside for health providers will be left open, to allow physicians and the unions an opportunity to offer input on an appropriate process for selecting candidates. The Minister will not exclude health care providers from sitting on boards and councils beyond the two designated seats, however, since boards must be representative of the community and each board will have both a physician and union member, few additional health care providers will likely be named to an RHB or CHC. Conflict of interest guidelines are being developed to alleviate any concern regarding the presence of health care employees on boards and councils.

RAT: We recommend the Minister balance the cost-savings that will result from integration of services with the need to reflect local concerns in making decisions about regionalization.

BTBC: - Not addressed.

RAT: We recommend the Hospital Group Boards in Vancouver remain intact.

BTBC: Vancouver Hospital Group Boards remain as follows:
A. Vancouver Hospital & Health Sciences Centre; BC Rehabilitation Society; the Arthritis Society
B. Chara Health Care Society (which operates Catholic health care institutions, including St. Vincent's, Mount St. Joseph's, and two long-term care facilities: St. Paul's Hospital and Holy Family Hospital)
C. BC Children's Hospital; BC Women's Hospital and Health Centre; Sunny Hill Health Centre for Children
D. BC Cancer Agency

RAT: We recommend the Minister introduce legislation to enable amalgamations requested by a local board or council.

BTBC: - Not addressed.

RAT: We recommend the Minister consider extending affiliation arrangements to smaller facilities and community services operated by societies with unique mandates.

BTBC: Not all health service providers will be required to amalgamate. There are the following exceptions:

- The following agencies can affiliate with RHBs/CHCs: denominational agencies; ethnic and service organizations on a case-by-case basis.
- The following agencies can contract with RHBs/CHCs: for-profit agencies; small community-based agencies which receive little funding; and agencies which receive a small proportion of their funding from the Ministry.

RAT: We recommend the Minister encourage arrangements, such as fundraising trusts, which would allow institutions to continue to publicize their role vis-à-vis particular client groups within an amalgamated structure.

BTBC: - Not addressed.

RAT: We recommend the Minister set standards for health care delivery and establish a mechanism to audit and report on the performance of providers.

BTBC: The Ministry will ensure accountability of RHBs/CHCs through:

- establishment of management contracts that specify the type of services to be provided and establish performance guidelines and standards
- approval of budget plans submitted annually by the RHBs/CHCs
- monitoring of regular financial and performance reports submitted by the RHBs/CHCs
- on-site visits and audits.

Each RHB/CHC will sign a service contract with the Ministry before the transfer of authority is approved. RHBs and CHCs will be expected to meet certain performance guidelines and standards, which will be monitored and audited by the Ministry in order to ensure the quality, accessibility and consistency of health care service is not compromised. These contracts will set out specific performance guidelines and principles covering areas such as waitlists, lengths of stay, and patient satisfaction, to ensure the right care is being provided to the right patients in the right setting. The results will be monitored and audited by the ministry, with results to be published in an annual report.

The “Core Services Report” issued under *New Directions* will still apply under *Better Teamwork, Better Care*, outlining the responsibilities of RHBs/CHCs in ensuring accessibility of service, quality of care, and availability of appropriate services to meet the needs of their particular regions or communities, when authority was transferred. The ultimate accountability for ensuring high standards, high quality, and consistency of health care throughout the province rests with the Minister of Health. Cross-disciplinary teams within the Ministry will monitor and audit the performance of the RHBs/CHCs to ensure the right care is being provided to the right patients in the right setting. The Ministry will intervene and corrective action will be taken if problems are identified.

RAT: We recommend the Ministry of Health be redesigned to reflect a health care leadership role rather than a service delivery role in a new regionalized system.

BTBC: With few exceptions, the Ministry of Health will withdraw entirely from the direct provision of health care services.

The role of the Minister and the Ministry of Health will be as follows:

- to establish and maintain the policy, legislative, and organizational framework within which publicly financed health care services are provided to provincial residents
- to define the core programs which will be provided by the health care system, to establish standards which those programs must meet and to monitor system performance
- to fund the health care system
- to ensure the coordination on system wide or interregional issues
- to provide an integrated information management system for the collection and dissemination of information
- to act as an advocate within government for a health perspective in all public policy

Where regional health boards exist, responsibility for delivery of Ministry of Health services will be transferred to the board. In those areas of the province where there are not regional health boards to assume responsibility for staff and services, Community Health Service Societies will be established to assume responsibility for Ministry of Health employees providing direct health care services in the area. This arrangement maintains the regional delivery of these services. The local public health unit will provide the infrastructure for the society which will exist solely to oversee the provision of community health services (i.e. public health, continuing care, and mental health services) in these areas. The boards of the Community Health Service Societies will consist of one representative from each of the community health councils in the area. One Ministry of Health representative will also be appointed to the Society Board.

RAT: We recommend the Minister consider retaining the boards of the regional hospitals in Prince George, Nanaimo, Kamloops and Kelowna and directing these boards to work with the local governing body to develop plans for integration of services.

BTBC: The role of these hospital Boards vis-à-vis the RHBs has not been defined.

APPENDIX C: Regionalization - A Cross-Canada Scan

Several provinces have devolved funding authority for acute care facilities, community services, and long-term care to the regional level. The three provinces that appear to be the furthest along towards autonomous regional governance are New Brunswick, Saskatchewan, and Alberta. No provinces have, as yet, regionalized their medical services budget. However, a review of the academic literature and the evolving experience of the new regional authorities across Canada leads one to believe that a push for regional funding for physician services is not too far off.

New Brunswick

New Brunswick has had 9 Regional Hospital Corporations (RHCs) operational since 1992. These RHCs are responsible for the budgets of individual hospitals within their geographic region. They are not responsible for the physician services budget. At the time the RHCs were introduced, the Nova Scotia Medical Society (NSMS) successfully argued that the benefits of a central physician budget, including economies of scale and a single fee schedule, were sufficient to exclude these monies from regional control. RHCs have been given the authority for managing physician resources in each region through the use of hospital credentialling.

Manitoba

The Manitoba government has divided the province into eleven Regional Health Authorities (RHAs). The newly appointed Boards of the RHAs assumed responsibility for the organization and management of health care delivery April 1, 1997. RHAs, which are appointed by the Minister of Health and exclude practising health care providers, will be responsible for making decisions related to regional needs, services, programs and care delivery. Manitoba Health will provide global regional budgets but the spending decisions within this budget will be made by the RHA Boards.

With respect to medical services, the RHAs will be making decisions related to medical staff appointments and reappointments, physician manpower planning, and medical staff by-laws. The Manitoba Minister of Health has stated that the provincially held fee-for-service agreement will remain intact until it expires March 31, 1998. Thereafter, it is possible that regional funding may include remuneration for physician services.

Saskatchewan

Since 1993, Saskatchewan has had 30 District Health Authorities (DHAs) which are responsible for identifying health needs, planning and coordinating the delivery of health care services, allocating a provincially set funding envelope to health care programs and institutions, and ensuring that medical services meet provincially set standards. The provincial government has defined a set of core benefits which must be provided in each district.

Saskatchewan's 30 DHAs do not have authority over the physician services budget. The province's two most populous regions (Regina and Saskatoon Districts) have stated that, at this point in time, they don't want responsibility for the physician services budget. This may only be a temporary phenomena. Physicians must be credentialed to a DHA with authority over several agencies, including hospitals, long-term care facilities, home care, mental health, and ambulance services. It is practically impossible to practice medicine without district privileges as access to all services, including laboratories, is restricted.

Alberta

Each of Alberta's 17 Regional Health Authorities (RHAs) are given 3 year financial targets from Alberta Health. They are responsible for developing a three-year business plan including both operating and capital components. Currently, RHA funding is based upon historical utilization patterns, however, government is pursuing a shift to "needs-based" funding for each RHA. RHAs do not have the funding authority for physician services. They have taken the position, at least temporarily, that they don't want the medical services budget.

Laboratory services are regionally funded. The AMA and Alberta Health have negotiated a provincial grid for pathologists' salaries. Each of the 17 RHAs must adhere to this grid. Salaried pathologists have the opportunity to be represented by the AMA in negotiations.

Table 1 - REGIONALIZATION ACROSS CANADA

Prov.	# of regional boards	# of people covered by each region (average or range)	Accountability of Regional Board (elected or appointed)	Physician representation on the regional board	Regional Board's authority to make decisions re: delivery of health and medical care in the region
NFLD	12 boards (6 institutional boards, 4 community health boards, and 2 Boards that are a combination of the above)	range 19,000 - 200,000	Appointed by the Minister.	Physician representatives are present on the 4 Community Health Boards	Regional Institutional Boards - Planning purposes with respect to utilization of hospital resources. Authority to close hospitals and/or beds. Regional Community
PEI	5	range 7,859 - 67,611	Initially appointed, subsequent members are to be elected.	One of the 5 regional boards has a physician member (appointed).	Authority rests with the provincial Health Agency.
NS	4	The population of four regions are: 350,000; 250,000; 150,000; 150,000.	Appointed, eventually will be elected.	1/3 of seats reserved for health professionals, guarantee from government to have MAC on medical issues.	Involved in the policy formulation and program development, however budgetary authority will remain central.
NB	7	average size 108,571; range 35,856-179,809	The Hospital Corporation Board members are mainly appointed by local communities about half appointed by Minister. Accountability to legislature through the Minister. (Government is considering moving towards elected Boards in the future.)	There is no formal physician representation on the Board, 3 non-voting members (VP medical, Chief of Staff, Medical Staff President).	Hospital Corporation Boards and their administrators are responsible for allocating resources and do not directly control who is admitted and treated; this is the domain of physicians. Clinical/technical decisions are made by physicians and other health care personnel.
PQ	18	range 18,000-2,000,000	Some are appointed and some are elected (Chair of Commission)	Chair of Commission Medicale Regionale (advisory body to regional board) elected by physicians.	Authority derived from Bill 120. Determine health care needs function within a closed regional funding budget. Do not have responsibility for physician budget.
ON	N/A	N/A	N/A	N/A	N/A
MB	11 (excludes Winnipeg)	range 25,000-96,000	Appointed	None	Full authority to organize health care delivery in the region within the budget provided by government. Some programs remain provincial (e.g. Cancer treatment programs) and outside jurisdiction of regional boards.
SK	31	range 12,000-245,000 (Saskatoon)	Both appointed and elected	Elected	Yes
AB	17	range 20,196-819,499	Currently appointed. In future, will be a mix of appointed and elected.	Physician representative is appointed by Regional Medical Organization. Physician representative does not have voting privileges	Responsible for provision of all health care with the following exceptions: provincial Cancer programs, Mental Health, Physician Fee-for-service budget.
BC	11 Regional Health Boards retained around major urban centres; 34 CHCs retained in rural/geographically isolated areas.	60,000 - 500,000	Fully appointed.	Two health care providers appointed as voting members of each RHB/CHC - one physician and one health care union representative.	Minister holds ultimate accountability for health care system.
YT	N/A	N/A	N/A	N/A	N/A
NWT	6	average size = 10,000	Appointed	Medical director of the region (no voting rights)	Autonomous

Source: Canadian Medical Association, 1996.

APPENDIX D: BCMA Regionalization Project Group Members

Zafar Essak, Chair
General Practitioner, New Westminster, BC

Iain Cleator
General Surgeon, Vancouver, BC

Joginder Grewal
Pathologist, Abbotsford, BC

Dennis Karpiak
Internist, Kamloops, BC

Sharon Lee
General Practitioner, Terrace, BC

APPENDIX E: BCMA Council On Health Economics And Policy (CHEP) Members, 1996/97

Arun Garg, Chair
Pathologist, New Westminster, BC

Geoffrey Appleton
General Practitioner, Terrace, BC

Marshall Dahl
Internist, Burnaby, BC

Ray Dykstra
General Surgeon, White Rock, BC

Zafar Essak
General Practitioner, New Westminster, BC

Jim Lane
General Practitioner, Port Coquitlam, BC

Mike Lawrence
General Practitioner, Vancouver, BC

Heidi Oetter
General Practitioner, Coquitlam, BC

Patrick Yu
Anaesthetist, Vancouver, BC

Par-BC Representative

Andrew Yu (PAR-BC, invited guest)
General Practitioner, Vancouver, BC

APPENDIX F: BCMA Submission To The Regionalization Assessment Team - August, 1996

Introduction

The BCMA provides this report in response to the July 5, 1996 announcement by Health Minister Joy MacPhail outlining the process for regionalization assessment and the subsequent request, on July 25, 1996, by Mr. Mike Farnworth, Chair, Regionalization Assessment Team, to make a presentation to the team and provide responses to a circulated consultation questionnaire.

The Honourable Joy MacPhail, Minister of Health and Minister Responsible for Seniors, has asked for a candid assessment of the strengths and weaknesses of regionalization in terms of how well it will help meet the objectives of protecting and improving health care for British Columbians now and in the future, and to assure the public that regionalization is managing the health system better so that more dollars are spent on direct patient care and less are spent on bureaucracy, waste and duplication. The caucus team has been given a specific mandate to assess regionalization in light of the new government's priorities for health care. They have a very tight time frame in which to conduct this assessment, with a report expected in September.

The BCMA offers this report in conjunction with the September 1994 BCMA policy position paper, Regionalization of Health Services in BC, to assist the team in conducting its assessment.

Our responses to the 13 questions circulated by the Regionalization Assessment Team have been grouped into four categories:

Governance
Boundaries
Efficiency
Public Participation

We strongly recommend, however, that the focus of this assessment be expanded to include other important aspects of regionalization currently impacting health care in British Columbia including core services and standards, regional funding, accountability, information systems, and system objectives. The 1994 BCMA policy position paper on regionalization provides further details and recommendations on these important issues.

Regional Governance

1. Should the responsibilities for the health care system be the same in all regions of the province? (i.e. CHCs in every region, RHBs in every region?)

The BCMA does not believe that a uniform governance structure will work in every region of BC. Regional governance is likely to function most effectively in those jurisdictions which have health care facilities and resources which are accessed predominantly by local residents.

The BCMA is concerned that regional governance is inappropriate for facilities or programs which have a broad-based, provincial mandate. We do not support a structure which has the Vancouver Regional Board responsible for both local programs and provincial programs such as the Cancer Control Agency and many of the tertiary care programs of St. Paul's Hospital, Vancouver Hospital, Women's Hospital, and BC's Children's Hospital. An alternate governance structure with a provincial mandate is essential to ensure that these facilities maintain a focus which extends beyond the boundaries of the Vancouver region and equitably serves all the citizens of British Columbia.

2. Based on your experience and knowledge, what could constitute the responsibilities of the RHBs?

The BCMA believes that RHBs should be responsible for:

- setting local health care priorities;
- evaluating the need for services within the region;
- identifying service gaps and proposing programs to address them;
- input into human resources and construction planning;
- developing links with other regions for the provision of highly specialized services, and;
- developing community-based programs.

One of the first tasks that should be undertaken by the RHBs is the detailed inventory of services provided within their region, with the purpose of identifying methods to improve efficiencies and reduce redundancies, and, in conjunction with the Ministry of Health, identify core health services that must be provided in each region.

3. Based on your experience and knowledge, what could constitute the responsibilities for CHCs?

One of the primary weaknesses of the *New Directions* initiative is the lack of a clear delineation of roles between RHBs and CHCs. In some regions, governance has become extremely complicated with a multitude of advisory committees reporting to various subcommittees of the Board. Experience in Europe and other Canadian provinces has shown that too many levels of health care governance are counterproductive and extremely costly. This has been borne out in several BC communities where CHCs have clearly stated their unreadiness to assume management of hospital facilities.

In general, the BCMA does not envision a meaningful management role for CHCs and believes they are a needless duplication of bureaucracy. Adequate local input can be obtained through proper administrative and committee structures reporting to a single regional authority. Consequently, the BCMA recommends that the CHC level of regional governance not be pursued on a province-wide basis. The Association recognizes, however, that a CHC structure may be appropriate for a few regions with distinct population clusters, e.g. Peace River/Liard and Skeena health regions.

4. According to your experience of working with CHCs and RHBs, what do you think the relationship between the CHCs and RHBs could be?

As mentioned above, the BCMA does not envision a productive governance role for CHCs with the exception of a few regions with distinct population clusters.

5. How could the membership of RHBs be determined?

Considering the importance of health care and the costs involved, it is imperative that authority remain in the hands of individuals that are directly accountable to the public. Consequently, RHBs must embody the democratic principles of accountability through direct election. In addition, conflict of interest guidelines must be clearly delineated and ensure that all BC residents, including practising health care professionals, are equally eligible to be elected or appointed to regional governing bodies. Appointments to RHBs must be kept to a minimum and only to meet specific, clearly identified needs.

The existing system of political appointments to RHBs and other positions of authority and management in the health care system has significantly undermined credibility with both providers and the public. This was most clearly illustrated when the then Health Minister dismissed the entire Capital Region Health Board and appointed a new Board. Actions such as this undermine public and professional confidence in regional governance.

Some appointed members to the RHBs and CHCs appear to be "single issue" representatives and it is difficult to see how they will be able to carry out their complex duties. Others, while well meaning, have a limited knowledge of health care issues and are now placed in the role of managing the system. Some Board members have resigned because of the political focus of activities rather than objective consideration of health care issues. Without election of members to the RHB, there is little room left for the public to indicate their priorities. As with other systems, accountability and authority cannot be severed. In a democratic society, elections provide the best form of accountability.

6. How could the membership of the CHCs be determined?

As mentioned above, the BCMA does not envision a productive governance role for CHCs with the exception of a few regions with distinct population clusters. Where CHCs are appropriate, their membership should mirror that of the RHBs as discussed in question #5.

11. What ought to be the role of the Ministry of Health in a regionalized health system?

The BCMA believes that a strong central Ministry, with good communications and input from regions and communities throughout the province, is required to ensure appropriate allocation of scarce health care resources. The regionalization experience in Europe has demonstrated that regional authorities are more susceptible to pressure from individual lobby groups than is a central administration, limiting the regional authority's ability to make objective allocation decisions. It has also been shown that where local authorities are responsible for the provision of services the resources provided to them are frequently insufficient to meet the needs of their region. Consequently, the transfer of responsibility for funding of health care services to local bodies has been closely followed by requests for transfer of taxation authority in these jurisdictions. Regional taxation authority too easily

becomes a slippery slope whereby elected provincial officials can divest themselves of responsibility for local health care programming.

The BCMA believes that global regional funding is inappropriate and would result in unequal levels of care between regions. As previously stated, there is a very real risk that taxation authority would be requested by regional authorities to meet their service needs. This would widen the gap between regions, with better care provided in wealthier regions and requests for subsidization to fill needs in lower income areas. In addition, small communities are concerned that service inequities will develop with more populous regions enjoying significantly superior health services.

The BCMA supports specific service regional funding provided government addresses important outstanding issues including: clearly defining the spectrum of programs and services to be funded regionally, development of a comprehensive regional funding formula, and clearly defining the source of funding and taxation authority where it applies or could apply in the future.

Core Services

The BCMA believes that defining core services and standards is an essential undertaking for the Ministry of Health as it embodies assurance to the public that essential health services will be maintained. The BCMA has reviewed the Ministry of Health's document, *Planning for Core Services and Standards in BC, An Interim Document* (November 1993). This document explains that, "core services refer to general categories of health services. . . and while . . . the standards for core services will provide objectives and outcomes for each general category . . . they will not mandate the type or level of specific services". According to this document, CHCs and RHBs will be given the latitude to organize the delivery of core services including, "the flexibility to replace existing programs with new and innovative initiatives", without clear provisions for meaningful input from physicians and other health care professionals in these local decisions. In reality, the specific services provided by each region may be significantly altered, seriously affecting the health care infrastructure, at significant cost, without the support of evidence. Clearly, this is not an acceptable approach to determining publicly sponsored programs. The public must be assured that a minimum standard of core services will be protected and provided in all regions. This concern is shared by the BC Health Association which responded to the Ministry's interim document by saying, ". . . the BCHA feels the definition of standards must be very specific and is concerned that there could otherwise be scope for potential abrogation of responsibility from regions to the province and from communities to the regions".

The BCMA believes that the priority should be to ensure that resources will not be shifted away from current care programs without objective, evidence-based outcome measures demonstrating the benefits of doing so. Input from physicians and other health care professionals is critical in the development of core health services to ensure that acute care services are maintained at acceptable levels and changes to existing programs are instituted on evidence-based evaluation of the costs and benefits. The BCMA and government must work co-operatively towards defining core medical services for the province.

12. What would be an effective governance structure for regional hospitals?

The BCMA is not convinced that abolishing hospital boards will lead to improved service delivery. Regional hospitals are very complex organizations and a single RHB may not be able to effectively manage multiple regional hospitals. The BCMA recognizes, however, that one size does not fit all. Multiple smaller facilities may be effectively managed by a single board. Consequently, the BCMA suggests that consideration be given to defining a minimum size standard above which hospitals must retain their governing board reporting to the RHB.

Boundaries

7. Are the current geographical boundaries appropriate?

Regional boundaries must reflect the natural, socio-political, and geographic divisions of the population, including current health care utilization patterns. There must be local public input into determination of boundaries. In addition, boundaries for health, education, and social services should be coterminous wherever possible.

The 20 existing BC health regions do not fit traditional utilization patterns and patient flow. For example, it is unrealistic to believe that the Cariboo health region can function independently. Failure to ensure that boundaries reflect the natural and traditional health care activities of the population will introduce unnecessary complexities in management and resource allocation. While inappropriate boundaries may not prevent individuals from receiving health care, they may result in those individuals not having adequate input into the decision-making of their health care system.

The BCMA is concerned that, currently, there are too many RHBs. *New Directions* has created 20 RHBs along with approximately 80 CHCs for a province with a population not larger than that of Greater Toronto, Greater Montreal or many American cities. New Zealand, a country with a population roughly equivalent to that of BC, and with similar geographic obstacles, initially attempted regionalization of health care with the establishment of 14 Area Health Boards (AHBs). In 1993, these 14 AHBs were abolished because of their ineffectiveness and replaced with just 4 Regional Health Authorities (RHAs), each serving a population ranging in size from approximately 650,000 to 1,100,000. Health Maintenance Organizations (HMOs) in the United States require even larger populations to achieve maximal economies of scale. Considerable monies could be saved by reducing the number of regions and the support each would require.

Efficiency

8. Will the current approach lead to reduced waste and duplications? If no, why not? If yes, how?

The BCMA believes the current approach to regionalization in BC will inappropriately redirect scarce health care dollars from patient services to administration. There is a great deal of evidence from Europe and Australia that regionalization of health care services

greatly increases the size of the health care bureaucracy. In times of increasingly scarce health care dollars, such an outcome is entirely inappropriate.

Adding two more levels of administration to health care delivery in BC, (RHBs and CHCs), will undoubtedly increase the costs of health care. A significant portion of the difference in health care spending between the USA and Canada today is directly due to the much lower costs of health care administration in this country. The addition of two layers of bureaucracy in each region, together with hiring the administrative expertise which each region will require, may well offset any potential cost savings in health service delivery. In addition, the potential exists for a lack of appropriate administrative skills and expertise at the local level. This will ultimately compromise the quality and efficiency of the health care system. As the region's range of responsibility broadens, so too do the resources required to enable these units to exercise their authority. Already, we have seen examples of large severance packages to rearrange the administrative “deck chairs” in some regions.

10. Amalgamation of health care facilities is the current mechanism for streamlining administrative costs and encouraging greater integration of care. Given the experience in your area, what is your perspective of amalgamation?

To date, we have witnessed more corporate “restructuring” than rethinking of health care delivery. From the viewpoint of the patient, in many circumstances this has resulted in services being further from home as services are centralized within the region. While in some cases there may be sound economic rationale to support this amalgamation, in many cases these changes have been implemented without an examination of the cost-benefit and simply justified on the basis of presumed economies of scale.

The BCMA is in favour of amalgamation of health care facilities as long as it can be shown to reduce administrative costs and not diminish the quality of patient care. However, the acute care system in BC has been pushed to the limit by current budget cuts and large population increases. The province has already seen bed reductions below the Royal Commission's projected requirement of 2.75 acute care beds per 1,000 population. BC's current bed ratios are significantly lower than the majority of Canadian provinces. Any further reductions to the acute care system may well place the health of the BC population at risk. Consequently, no further reductions in per-capita real funding to hospital services should occur in BC until alternative services are in place and proven effective through evidence-based pilot projects.

Professional and Public Participation

9. Public participation was intended to create a more responsive and flexible health system. What is the status and effect of this strategy in your area?

Public participation has been limited. Even when public participation was at its height in the early days of *New Directions*, there were criticisms that the focus groups and reports were, to a large degree, directed by the appointed facilitators.

There is a high level of cynicism, both public and professional, with the regionalization process. It is generally felt that public and token professional participation in the regionalization process was for political posturing rather than meaningful input.

The BCMA's attempts to ensure the establishment of Regional Medical Advisory Committees (RMACs), with terms of reference that embody principles of accountability through a democratic process, and serving the public interest by having a voting presence at all deliberations of the Board, have met with opposition from government.

Summary

13. In your opinion, what are the biggest challenges to the process of regionalization?

If regionalization of health care in BC is to be effective, there must be an early and ongoing buy-in of the principal health care stakeholders. The BCMA has continued to strongly support its members' activities at the local planning level, however, the reform process has discriminated against active physician participation. The doctors of BC have been intentionally left out of the process and repeatedly told that our opinion is not needed nor wanted. Consequently, planning decisions have been disproportionately influenced by the non-medical community. This is a primary reason why, to date, *New Directions* has failed. As described by one of the members of the BCMA, "mutual respect goes a long way when we face difficult times...however...the process that is presently in place to implement regionalization is eroding the working relationship we have worked so long to establish".

What is Wrong with *New Directions*

As previously stated, the BCMA believes that the scope of this assessment must be broadened to include other important aspects of regionalization including core services and standards, regional funding and accountability, information systems, and system objectives. Each of these areas is addressed in detail in the 1994 BCMA policy position paper on regionalization which is appended to this report.

The BCMA cannot endorse the *New Directions* initiative until government addresses the following issues to the Association's and the public's satisfaction:

1. current government definitions of core health and medical services and standards need considerable refining, including consultation with the medical profession. The regions must be held accountable for providing these services;

2. government should concentrate on developing one level of regional governance and abandon the CHC governance model on a province-wide basis. The BCMA recognizes that CHCs may be productive in a few regions with distinct population clusters;

3. government must resolve <u>all</u> outstanding boundary issues before proceeding with the proposed transformation to the RHBs. The number of health regions should be significantly reduced;

4. conflict of interest guidelines must be clearly delineated and ensure that all BC residents, including practising health care professionals, are equally eligible to be elected or appointed to regional governing bodies;

5. the accountability of regional governing bodies must be improved through direct election of RHB members;

6. CEOs must be hired by credible, elected regional boards, not interim boards consisting of political appointees. Otherwise, the CEOs will not have the respect and credibility necessary to perform their difficult task;

7. government must be diligent to ensure that this shift to regional governance does not result in an increase in the size of the current health care bureaucracy nor increase administrative costs;

8. key provincial resources, such as the BCMA and other professional organizations, and local resources, such as practising physicians and other health care professionals, must be better utilized in regionalization planning initiatives;

9. there must be a legislative requirement for Regional Medical Advisory Committees (RMACs) to all RHBs, comprised of locally elected physicians. The Chair of the RMAC must have a voting presence on the RHB, and;

10. government must commit to piloting regional governance in a few selected regions. There already exist some RHBs which are sufficiently advanced to serve as pilot projects, e.g. Simon Fraser and Upper Island health regions. These pilots must proceed through objective, evidence-based outcome assessment prior to province-wide implementation of a regional governance model.

APPENDIX G: Summary Of The BC Health Association Submission To The Regionalization Assessment Team, August 1996

Changes have been recommended where they are required to meet the following objectives: optimize the value of public dollars spent on direct service delivery, maintain professional standards of quality and access to health care, achieve administrative & clinical efficiencies, and reduce bureaucracy, waste, and duplication.

GOVERNANCE CHARACTERISTICS

Philosophy of Governance - Structures, roles, responsibilities, and reporting relationships must be established by the government, thus alleviating the existing confusion around accountability and responsibility. Also, it must be decided whether the Minister and Ministry of Health or the regional health boards are ultimately accountable.

Experience and Knowledge - Experienced individuals at the governance level, in management, and at the clinical interface are absolutely necessary to ensure that the reform initiatives are carried out effectively. We would strongly suggest that the current RHBs and CHCs be enhanced and strengthened by the inclusion/addition of experienced trustees of health care facilities and agencies.

A New Culture - The health system should be redesigned to reflect a client-centered culture, rather than the existing principle-driven health system.

ROLE DEFINITION

Role of Regional Health Boards - Maintain the status quo, or give the RHBs full responsibility for planning, funding, and managing all health care issues in the region

Role of Community Health Councils - Abandon CHCs in all areas, leave them in rural areas with responsibilities delegated from the RHB, or make them the focus of decision making, running all services.

Role of Ministry of Health - Establish the overall health budget, allocate funds within an established policy framework, establish standards of services and accessibility, hold RHBs accountable for results and outcomes, maintain an active planning role, and intercede as required to ensure ministry objectives are met.

Role of existing facility boards - Abolish boards once amalgamation has taken place or maintain boards either to govern facilities or to play an advisory role in promoting the quality of patient care.

Role of physicians - Maintain the status quo, transfer responsibility for physician manpower and planning and payment from MSP to RHBs (MSP to maintain responsibility for provincial planning and standards) or make the physician representative a voting member on the RHBs.

Role of independent health practitioners - Maintain status quo, relax professional boundaries and access to health care facilities, or review health professions' inter-relationships from a systems perspective.

STRUCTURES

Number of Regions - Retain 20 current regions, consolidate several regions to create a total of 15-16, or reduce the number of regions to 7-8.

Inter-regional Mechanisms - Leave as is with no formal mechanisms and establish provincial advisory committees for special populations, tertiary care, etc.; establish formal interregional mechanisms for clinical planning, provision of some support services, patient referrals; or establish a separate governance structure for provincial/tertiary programs.

Funding Allocation Mechanisms - Maintain the status quo or add a policy committee of regional representatives to provide input on overall provincial funding methodology and policy issues.

Composition of Boards and Councils - Maintain the board/council composition as is (1/3 appointed, 1/3 elected, 1/3 from elected officials), ensure that new appointments include a special focus on individuals with specific experience and expertise in health governance, or the Minister to appoint all members.

GOVERNANCE OPTIONS

Macro Region Model - This model would be created by the amalgamation of the current 20 regions into 8 larger regions. The new regions would have boards made up entirely of appointed members and would have the ultimate authority over service planning and allocation of resources. It would be efficient in reducing overall costs of service delivery, improving value-for-money, and re-focusing the Ministry of Health role towards strategic direction.

Mixed Model - The number of RHBs and CHCs under this model could vary depending on established criterion. Three alternative RHB/CHC definitions vary in their allocation of responsibilities yet all accomplish the government priority of increasing innovation. None of them achieve cost-containment over a short time frame.

Community Based Model - The community based model gives local bodies responsibility for some service planning, resource allocation, and complete governance responsibility for services at the local community level, while the main authority for overall service planning and rationalization as well as resource allocation would rest with the Ministry of Health. This would increase citizen participation and local autonomy of decision making, but would not achieve improved health outcomes or increase the degree of rationalization of clinical/ support services.

OTHER OPTIONS

Integrated health systems represent the highest probability of achieving the twin goals of delivering quality of care and containing cost escalations, and foster an environment where the optimum balance between these potentially conflicting objectives can be achieved.

CONCLUSION

A single model will not work for this province's unique requirements, with its diversity of population characteristics and density, geography, climate, and transportation patterns. There needs to be a clear definition of roles and responsibilities of all parts of the system, including the Ministry of Health, the Regional Health Boards, the Community Health Councils, and the Regional Hospital Districts. Whatever structures are to be maintained and the roles assigned to them should be as streamlined as possible and every effort made to avoid duplication and overlap of responsibilities. We support the concept of Regionalization and the delegation of increased decision making to bodies which reflect local priorities. Such a system must not, however, result in the balkanization of health services or erosion in equity of access or quality of health services for all British Columbians.

APPENDIX H: Ministry Of Health Restructuring, January 1997

Province of
British Columbia

ASSISTANT DEPUTY MINISTER

Ministry of Health and
Ministry Responsible
for Seniors

1515 Blanshard Street
Victoria
British Columbia
V8W 3C8

January 13, 1997 A82796

Dear Stakeholder:

I am writing to notify you of changes to the structure of the Ministry of Health designed to facilitate the implementation of regionalization.

As described in the attached document, the Ministry of Health has appointed five Regional Directors who will assist Regional Health Boards (RHBs) and Community Health Councils (CHCs) to become fully operational, and who will monitor health care service delivery in their geographical areas.

Regional Director positions have been established for: the North; Thompson/Okanagan/Kootenays; Fraser Valley; Vancouver/Richmond/Burnaby/ Simon Fraser; and Vancouver Island/Coast Garibaldi/North Shore. The names and telephone numbers of the persons assigned to these positions are listed on the attached document.

The Regional Directors will be the major point of contact with the Ministry of Health and will be responsible for addressing questions related to the full range of health care services within their specified areas. They will be available to respond to any questions you have regarding health service delivery; each will be supported by a team of staff with expertise in various health sectors. Seven implementation work groups have also been established to assist the Regional Directors to resolve technical and support issues. The Regional Directors will report directly to me.

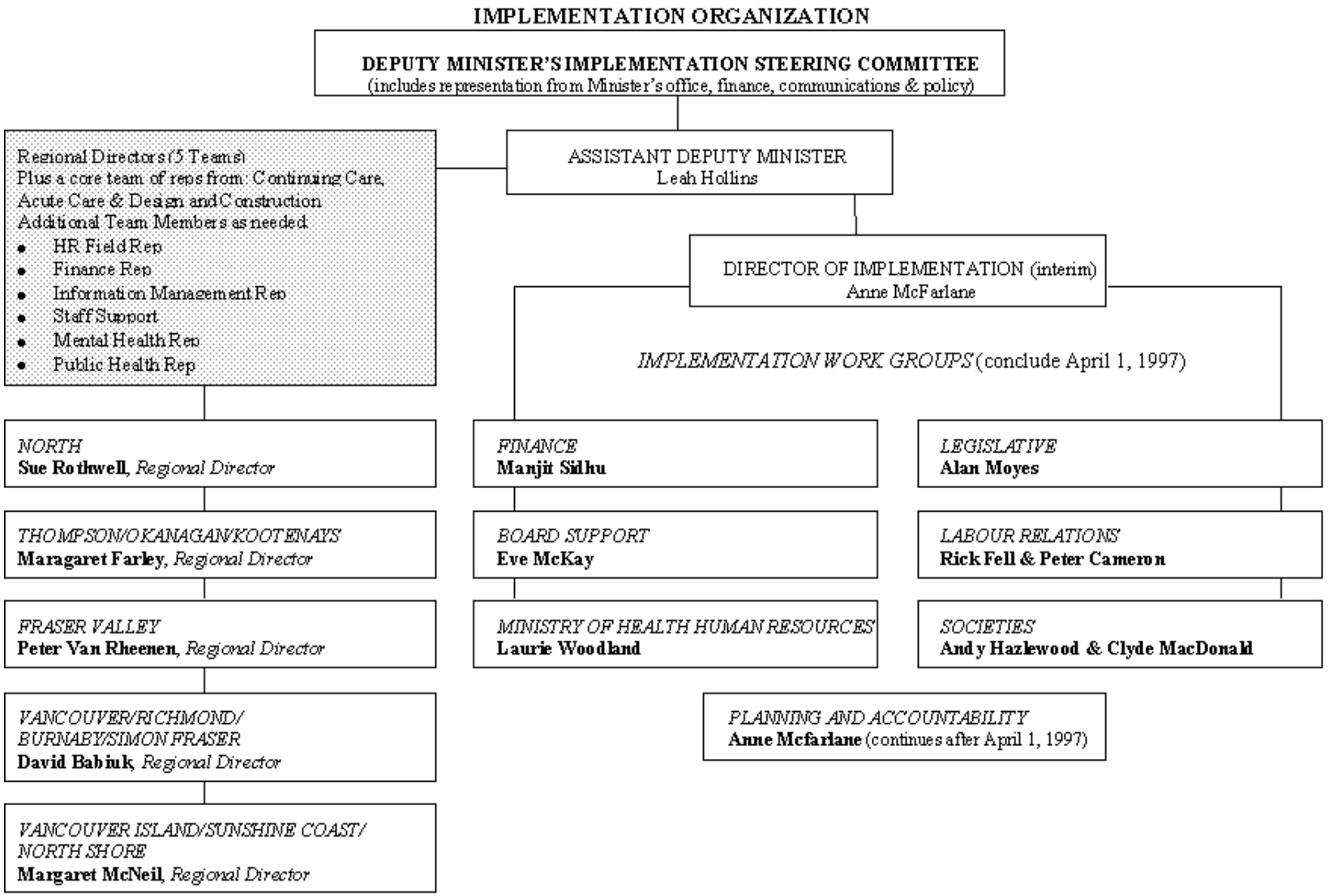
I trust you will find this arrangement beneficial in your communications with the Ministry during this time of restructuring.

Yours sincerely,

Leah Hollins

Leah Hollins
Assistant Deputy Minister
Acute & Continuing Care Program

Attachment


IMPLEMENTATION ORGANIZATION
DEPUTY MINISTER'S IMPLEMENTATION STEERING COMMITTEE
(includes representation from Minister's office, finance, communications & policy)
Regional Directors (5 Teams)
Plus a core team of reps from: Continuing Care, Acute Care & Design and Construction
Additional Team Members as needed
HR Field Rep
Finance Rep
Information Management Rep
Staff Support
Mental Health Rep
Public Health Rep
ASSISTANT DEPUTY MINISTER
Leah Hollins
DIRECTOR OF IMPLEMENTATION (interim)
Anne McFarlane
IMPLEMENTATION WORK GROUPS (conclude April 1, 1997)
NORTH
Sue Rothwell, Regional Director
THOMPSON/OKANAGAN/KOOTENAYS
Maragaret Farley, Regional Director
FRASER VALLEY
Peter Van Rheenen, Regional Director
VANCOUVER/RICHMOND/ BURNABY/SIMON FRASER
David Babiuk, Regional Director
VANCOUVER ISLAND/SUNSHINE COAST/ NORTH SHORE
Margaret McNeil, Regional Director
FINANCE
Manjit Sidhu
BOARD SUPPORT
Eve McKay
MINISTRY OF HEALTH HUMAN RESOURCES
Laurie Woodland
LEGISLATIVE
Alan Moyes
LABOUR RELATIONS
Rick Fell & Peter Cameron
SOCIETIES
Andy Hazlewood & Clyde MacDonald
PLANNING AND ACCOUNTABILITY
Anne Mcfarlane (continues after April 1, 1997)

ORGANIZATIONAL STRUCTURE

Implementation of regionalization will be managed through the office of Leah Hollins, ADM, Acute and Continuing Care Programs. Five Regional Directors and a Director of Accountability, Policy and Standards have been established under this program area. Each Regional Director will work with a core Regional Implementation Team consisting of a representative from Continuing Care, Acute Care and Design & Construction. When required, team members will be added from Human Resources, Finance, Information Management, Staff Support, Mental Health and Public Health and Preventive.

The area responsibilities for Regional Directors includes the following:

NORTH

Regional Director: Sue Rothwell
O: (250) 952-1047 F: (250) 952-1282
Email: serothwe@bcsc02.gov.bc.ca

RHB: Northern Interior

CHCs: Fort Nelson –Liard
Merged Chetwynd, Peace River SE & Tumbler Ridge
Merged Hudson's Hope & Ft. St. John
Queen Charlotte Islands – Haida Gwaii
Merged Smithers & Houston
Kitimat & Area
North Coast
Stikine
Upper Skeena
Snow Country
Terrace & Area
100 Mile House & District
Central Chilcotin
Quesnel & District
Bella Coola Valley & District

Nisga'a Valley Health Board

Community Health Services Socieites:
North West
Peace Liard
Cariboo

THOMPSON/OKANAGAN/KOOTENAYS

A/Regional Director: Margaret Farley
O: (250) 952-1271 F: (250) 952-1282
Email: mfarley@bcsc02.gov.bc.ca

RHBs: Thompson
North Okanagan
South Okanagan/Similkameen

CHCs: Elk Valley & South Country
Cranbrook
Kimberley
Columbia Valley
Creston & District
Boundary
Nelson & Area
Castlegar & District
Arrow Lakes/Upper Slocan
Greater Trail

Community Health Services Societies:
East Kootenay
West Kootenay

FRASER VALLEY

Regional Director: Peter Van Rheenen
O: (250) 952-1753 F: (250) 952-1289
Email: pvanrhee@bcsc02.gov.bc.ca

RHBs: Fraser Valley
South Fraser Valley

VANCOUVER/RICHMOND/BURNABY/SIMON FRASER

Regional Director: David Babiuk
O: (250) 952-2329 F: (250) 952-1289
Email: dwbabiuk@bcsc02.gov.bc.ca

RHBs: Merged Vancouver & Richmond
Merged Burnaby & Simon Fraser

Regionalization Implementation *Better Teamwork, Better Care*

VANCOUVER ISLAND/SUNSHINE COAST/NORTH SHORE

A/Regional Director: Margaret McNeil
O: (250) 952-1160 F: (250) 952-1282
Email: mmcneil@bcsc02.gov.bc.ca

RHBs: North Shore
Central Vancouver Island
Capital

CHCs: Sea to Sky
Sunshine Coast
Powell River
Central Coast (Bella Bella)
Mt. Waddington
Merged Campbell River & Nootka
Comox Valley

Community Health Services Societies:
Coast Garibaldi
Upper Island/Central Coast

IMPLEMENTATION WORK GROUPS

Six work groups have been established within to assist Regional Directors teams with a wide range of implementation tasks. These groups will function until March 31, 1997. An ongoing Planning and Accountability work group will address the "accountability provisions" in the Funding and Transfer Agreements.

Finance: Manjit Sighu, Chair

Responsible for developing financial arrangements, funding and program agreements, accounting and reporting policies, and the contract template between the Ministry and regional health authorities.

Legislative: Alan Moyes, Chair

Responsible for drafting Minister's Orders and Orders in Council to facilitate implementation of regionalization. Will review any legislative changes required for the long term.

Board Support: Eve McKay, Chair

Responsible for working with the Minister's office in facilitating the appointment process for boards and councils and to provide support to the new boards and councils including training and guidelines for board operations.

Labour Relations: Rick Fell, Chair
& Peter Cameron, Consultant

Responsible for managing issues related to the establishment of transfer agreements for MoH and Municipal Health Department staff going to RHBs and for MoH staff going to CHSSs, CEO severance and placement coordination, implementation plan for Executive & Non-Contract Compensation program and the process for union representation on RHBs & CHCs.

Human Resources: Laurie Woodland, Chair

Responsible for overseeing the details of Ministry of Health staff transfers to RHBs or Community Health Services Societies.

Community Health Services Societies:
Andy Hazlewood, Chair and Clyde MacDonald

Responsible for developing the operational framework for the societies.

Planning and Accountability:
Anne Mcfarlane, Chair

This work group will extend beyond the Phase II implementation period which ends March 31, 1997. It will focus on developing a process for the Ministry to audit performance and report annually on performance outcomes. This will be a joint Ministry of Health and industry committee.

ROLE OF GOVERNMENT, MINISTRY OF HEALTH & HEALTH AUTHORITIES

Role of government:

- to establish and maintain a health care system which provides all residents with reasonable access to necessary health care services of appropriate quality at a cost which is affordable and sustainable.

- to ensure a health perspective in all public policy.

Role of the Minister and the Ministry of Health:

- to establish and maintain the legislative, policy and organizational framework within which publicly financed health care services are provided to residents of British Columbia.

- to define the core programs which will be provided by the health care system, to establish standards for those programs, and to monitor system performance.

- to fund the health care system.

- to ensure coordination on system wide or interregional issues.

- to act as an advocate within government for a health perspective in all public policy.

  NOTE: With few exceptions, the Ministry of Health will withdraw entirely from the direct provision of health care services to BC residents, transferring those functions and staff in an orderly fashion to regional health authorities. There will be a reduced administrative staff at the Ministry.

Role of Health Authorities (RHBs, CHCs and Community Health Services Societies):

- to plan for the health care needs of the population served by the appropriate health authority. The health authorities will be required to submit multi-year Health Plans, updated annually, to the Minister. Following approval or change by the Minister, these Health Plans will become public documents.

- to allocate funding received from the Ministry of Health, to health care facilities and agencies providing services to the population of a health authority.

- to manage some services, that is to be the employer of staff for programs, services and amalgamated agencies and the funder of affiliated programs or agencies in accordance with the appropriate responsibilities designated to each health authority.

APPENDIX I: Regional Medical Advisory Committees Terms Of Reference

Medical Advisory Committees are an integral component of the health care system. These committees provide reassurance and protection to the public through a process of full medical input to governing boards of public health care facilities. All governing health boards must have duly constituted MACs to ensure that accessible, reliable, safe and effective medical services are provided.

The Regional Medical Advisory Committee (RMAC) is a committee of the Governing Health Board which may be a Regional Health Board or a CHC comprised of physicians selected by physicians of the region to provide advice directly to the Health Board through the RMAC Chair, and report back to regional physicians on:

1. the provision of medical care to the population of the Region,

2. the monitoring of the quality, quantity, effectiveness, and sufficiency of health care provided to the population of the Region and the reporting on the quality of that care to the Health Board, and;

3. the continuing medical education, research and teaching in the Region.

A. COMPOSITION

1. MEMBERSHIP

i) Members of the RMAC will include:

a) representatives from medical disciplines (elected by physicians within each discipline) to a maximum of anaesthesia, diagnostic services, family practice, medicine, obstetrics and gynaecology, paediatrics, psychiatry, and surgery, and;

b) representative president(s) of the facility medical staff, where applicable;

c) physician members-at-large appointed by the Regional Medical Society(ies) within the region (or elected by physicians within the region in the absence of a regional medical society);

d) the Region CEO, as an *ex officio* non-voting, member;

e) the physician member of the Health Board;

f) the Senior Medical Health Officer for the region;

g) the Senior Medical Director for the region.

ii) Appointments should be such that the committee reflects the medical services available within the region.

iii) Each member-at-large will be appointed for a term of two years and these appointments will be staggered, therefore, in the first year one half of the member-at-large will be appointed for one year only.

2. CHAIR/VICE CHAIR

The RMAC Chair/Vice Chair will be elected annually from within the RMAC membership, excluding the Senior Medical Health Officer, Senior Medical Director, CEO and physician member of the Health Board.

3. REPORTING RELATIONSHIP TO THE HEALTH BOARD

i) The Chair of the RMAC will be a voting member of the Health Board.

ii) The RMAC will have a dual reporting relationship, reporting both to the Board and the Senior Administrator for the region on all matters.

B. MEETINGS

Meetings of the RMAC will be held monthly and at the call of the Chair, with a minimum of 10 meetings to be held each year.

C. REMUNERATION

Members of the RMAC will be compensated for all committee work at the BCMA negotiated sessional rates, in force at the time, to be paid by the Health Board.

D. AUTHORITY

(i) The RMAC will appoint Chairs and members of committees to advise the RMAC. These committees will be chaired by members of the RMAC.

a) Standing Committees of the RMAC (where appropriate)

1) Credentials Committee (where appropriate)
2) Medical Quality Improvement and Resource Utilization Committee
3) Physician Supply Committee
4) Pharmacy and Therapeutics Committee (where appropriate)
5) Health Education and Continuing Medical Education Committee

b) Other Committees as Deemed Necessary

F. DUTIES

1 MEDICAL ADMINISTRATION

a) to provide recommendations with respect to

i) the health needs of the population of the region,

ii) the quality, quantity, effectiveness, and sufficiency of health care provided to the population of the Region and the reporting on the quality of care to the Health Board,

iii) the planning for programs of health care delivery in the region.

b) make recommendations to the Board on the development, maintenance, and updating of bylaws and rules and regulations pertaining to medical care provided in publicly funded facilities within the region, and;

c) advise the Health Board and CEO on matters pertaining to clinical organization, medical equipment, and other relevant medical administrative matters.

2. CLINICAL PRIVILEGES

a) Review recommendations from committees and facility MACs where applicable concerning the appointment and re-appointment of the facility Medical Staff members and the delineation of their clinical privileges, and;

b) make recommendations for disciplinary measures to be applied for violation of provisions of Bylaws or Rules and Regulations. The physician under consideration will have the right to appeal before the RMAC, the Health Board, and ultimately to the Medical Appeal Board under the *Hospital Act* or equivalent legislation.

c) the RMAC will make recommendations to the Health Board with respect to awards and other honours and, to the restriction, modification, suspension, revocation, non-renewal or maintenance of a physician's privileges to practice within the publicly funded health care facilities within the Region and may require a physician to appear before it whenever necessary to carry out its duties.

3. RESPONSIBILITY FOR QUALITY OF CARE

a) Receive, study and act upon reports from facility MACs, and committees concerning the review, analysis and evaluation of clinical practice of physicians in order to determine the quality of medical care rendered in the Region.

b) make recommendations concerning the establishment and maintenance of professional standards in the Region's publicly funded health care facilities in compliance with the *Hospital Act* and all other relevant legislation, bylaws, Rules and Regulations, and policies of the facility medical staffs, and;

c) submit regular reports on the quality and availability of health care provided, in relation to professional standards, in publicly funded health care facilities and programs within the Region.

4. PHYSICIAN SUPPLY PLANNING

Make recommendations regarding physician human resource requirements to meet the medical needs of the population of the Region, within the context of provincial physician resource planning.

5. OVERSEE PROFESSIONAL AND ETHICAL CONDUCT OF PHYSICIANS

Report any concerns related to the professional and ethical misconduct of physicians to the College of Physicians and Surgeons of British Columbia.

6 HEALTH EDUCATION AND CONTINUING MEDICAL EDUCATION

a) Advise and assist with the development of formally structured ongoing programs of continuing medical education;

b) advise and assist with programs on continuing education of other health care providers in the Region's publicly funded facilities;

c) advise and assist with education programs on health issues for the public at large, and;

d) provide recommendations on teaching and research.