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auditor general's comments

The restructuring of health care service delivery systems is occurring across the country, with many provincial governments transferring responsibility for the delivery of health services to local or regional governing bodies. This is being done to make these services more responsive to local needs, to better integrate and coordinate them, and to deliver them more cost effectively.

In British Columbia, regionalization started on April 1, 1997 when responsibility for health care services was transferred to regional health boards and community health services societies, as well as to a number of community health councils. The transfer of responsibilities to the remaining community health councils was completed by October 1, 1997. As a result, health authorities now have assumed responsibility for about $4 billion of annual expenditures, which represents more than half of the total health care budget of the Province. The new health authorities are accountable to the Minister of Health and Minister Responsible for Seniors, the Minister for Children and Families, and their local communities for managing the resources entrusted to them.

Clearly, a transfer of responsibility of this magnitude is a significant undertaking. For it to succeed, an appropriate governance and accountability structure is critical. Such a structure must ensure that all parties fully understand their new roles and responsibilities for providing health care services, and that they are accountable for their performance.

To help promote the future success of this initiative, my Office undertook to assess what mechanisms the Ministry of Health has put in place to achieve effective governance and accountability for performance. We found that both governance and accountability need to be improved and strengthened in a number of areas.

We recognize that the regionalization process is an ambitious and complex undertaking that will take time to implement. We also acknowledge and commend the considerable work already done by the ministry to move the process ahead. I believe this report will support the work of the ministry and will contribute to improved performance and accountability.

George L. Morfitt, FCA
Auditor General

Victoria, British Columbia
March 1998

highlights

a review of governance and accountability in the regionalization of health services

In the spring of 1997, the British Columbia government, through the Ministry of Health and Ministry Responsible for Seniors, embarked on a major health reform initiative: that of regionalizing the delivery of health care services in the Province. This initiative, "Better Teamwork, Better Care," replaced the "New Directions" initiative begun five years earlier.

For any undertaking as important as this to succeed, it is critical that an appropriate governance and accountability structure first be established. In this case, an appropriate governance structure would ensure that all parties involved—the Ministry of Health, Regional Health Boards, Community Health Councils, and Community Health Services Societies—clearly understand their roles, responsibilities and authority, as well as their obligations to be held accountable for performance.

Purpose and Scope of Review

We conducted this review to assess whether the governance and accountability mechanisms put in place by the ministry for transferring responsibility for health services to the newly created health authorities are appropriate to achieve the objectives of regionalization. As well, we sought to identify areas where improvements could be made to assist the ministry and the government.

Our review looked at the processes in place on April 1, 1997, when responsibility was transferred to about half of the health authorities (boards, councils and societies). The processes we focused on were those related to the responsibilities, authorities and accountabilities of those bodies. Our work was carried out between April 1997 and July 1997.

A review is different from an audit. An audit involves a comparison of actual performance of an organization, or a program, against a standard of performance which is based on reasonable expectations of legislators and the public. In this case we carried out a review because there are no generally accepted standards or benchmarks to compare performance against. We identified the critical issues relating to the topic in question and looked at what is happening

locally and in other jurisdictions, with a view to obtaining information that would be helpful in making changes if appropriate.

We obtained information for the review from three main sources: literature, policy documents and interviews. Interviews were conducted with staff from the Ministry of Health, Ministry for Children and Families, the Office of Agencies, Boards and Commissions in the Ministry of Finance and Corporate Relations, and the Health Minister's Office. At the start of our review, 11 Regional Health Boards, 8 Community Health Councils and 7 Community Health Services Societies were operational. Of those, we visited 6 boards, 3 councils and 3 societies and conducted interviews with the Chairs, Chief Executive Officers, and other board members.

Overall Conclusion

The regionalization process is complex and will take a long time to implement fully.

Fortunately, the initiative has the general support of the health authorities, as does the Minister of Health's decision to have the transfer completed by October 1, 1997.

The ministry has done considerable work since the Minister's announcement of "Better Teamwork, Better Care," on November 29, 1996, to move this ambitious undertaking ahead. However, at the time of the review, certain key components of the governance and accountability mechanisms necessary for the ministry to determine whether the objectives of regionalization are being achieved needed to be established and implemented. Among the most important of these is the ministry's need to clearly communicate its vision and strategic direction for the health care system; to clarify the roles and responsibilities of all parties; to review regional planning processes in areas where there are both Community Health Councils and Community Health Services Societies, to ensure health services across and between communities are coordinated and achieve efficiencies; to improve the way the ministry selects and appoints people to health authorities; to develop clear performance targets and evaluation measures; and to reassess its accountability reporting needs.

Key Observations

The health services community generally supports the regionalization initiative

The people we interviewed in our review generally supported the regionalization initiative and want to make it work. For the most part, members of the health care community recognize that regionalizing health services in the Province is a complex undertaking that will require all parties to commit significant time and resources to make the new process work effectively and efficiently.

The Ministry of Health's vision for "Better Teamwork, Better Care" has not been as well communicated as it needs to be to allow the health authorities to set their strategic direction

The ministry's vision under New Directions was one of "healthy citizens and healthy communities." Under Better Teamwork, Better Care the ministry established a goal of "improved health care for people." This goal has shifted the system from a broad focus on the health of the population to a more specific focus on the health care services provided to the people of British Columbia.

With this change in focus, we found that the ministry has not clearly communicated to the health authorities whether its earlier vision of "healthy individuals, healthy communities" is still a priority and, if it is, how it links to Better Teamwork, Better Care. As a result, many of the health authorities remain focused on health and health status and not on health care services. To provide clear direction to the health authorities, the ministry needs to communicate a clear vision of where it sees the health care system going in the future. It must then develop a strategic plan based on its vision. The health authorities can then use the ministry's plan as a guide to develop, or realign, their own strategic plans and operations and can ensure that their direction is compatible with that of the ministry.

Not all parties involved in the initiative understand clearly what their and others' roles and responsibilities are

Regionalization has changed the way health care services are to be governed and managed in the Province. In this new environment, it is important that the roles and responsibilities of the ministry, as well as those of the health authorities, be clearly defined, flow logically from the overall direction of the ministry, and be understood by all parties.

The *Health Authorities Act* of 1993, with its subsequent amendments, sets out the overall responsibilities of the Regional Health Boards, Community Health Councils, and the Minster of Health and Minister Responsible for Seniors. The Community Health Services Societies were created under the *Society Act,* which does not provide any description of the responsibilities specific to these societies. Instead, those responsibilities are outlined in a ministry background paper.

When health authorities assumed responsibility for health care, the ministry entered into an agreement with them. The Funding and Transfer Agreement sets out the obligations of the health authorities and includes that of compliance with requirements established by the ministry regarding the management and delivery of health services. At the time of our review, the requirements had not yet been stipulated.

We found that the health authorities we visited have a general understanding of their roles and responsibilities. However, some are confused about the boundaries of their authority, and in particular they do not have a clear understanding of what types of decisions require ministry approval prior to implementation.

Thus to ensure that all parties—health authorities and the ministry—know clearly what is expected from them, the roles and responsibilities of the health authorities and of the ministry should be further clarified and communicated.

In areas of the Province having both Community Health Councils and Community Health Services Societies, no one body is designated to ensure that planning for health services across and between communities are coordinated and achieve efficiencies

The *Health Authorities Act* states that each Community Health Council has responsibility for developing a community health plan and integrating services in the community. In practice, however, there is confusion about what this means. It is not clear if the Act is referring to only the services that the Council is responsible for or to all services in the community—in which case, responsibilities would overlap with those of the Community Health Services Societies. Ministry documents are unclear about the planning responsibilities of the societies for the services they govern, stating that they are to participate as equal partners with Community Health Councils in joint health planning rather than taking the lead in the process.

Two of the councils and all of the societies we visited expressed concern about this lack of clarity and its potential for creating problems such as inadequate regional planning for acute and continuing care services, uncoordinated planning overall, increased competition for funding, fragmentation of services across communities and lost opportunities to create efficiencies.

The ministry should review the planning responsibilities of the councils and societies to ensure that the broader health issues in the region are appropriately addressed, and that a coordinated approach for planning is established across communities.

The current process for recruiting, selecting and appointing candidates to health authorities can be improved to ensure that the best qualified people fill the positions

The newly appointed health authorities are to be responsible for about $4 billion annually of health care expenditures, which is more than half of the annual budget of the Ministry of Health. It is therefore important that appropriate processes be in place to ensure that the best possible people are recruited, selected and appointed to govern the authorities.

We found that the current process for recruiting, selecting and appointing candidates to the health authorities attempts to ensure that the candidates selected satisfy certain requirements in terms of geographic representation and equity. However, the recruitment, selection and appointment process does not identify the necessary knowledge, skills and abilities of individual governors, nor does it stipulate what the composition of the authority as a whole should be to enable members to carry out their mandate effectively.

Before the next set of appointments to health authority board positions, the ministry and the health authorities should clearly identify the knowledge, skills, experience and other attributes required of board members and establish objective criteria for evaluating applicants and nominees. This will significantly improve the chances that the people selected will be able to meet the demands of the positions being filled.

The Ministry of Health understands the need to measure performance and is currently working to develop a suitable accountability framework

The ministry, although it currently collects financial and statistical information, has not yet established what level of performance it expects the health authorities to achieve, nor has it developed mechanisms for evaluating performance in relation to the regionalization of health services. The ministry has also not yet provided the health authorities with indicators or targets against which their performance will be measured.

The ministry is aware of the need to measure its performance and that of the health authorities and is currently working with representatives of the health industry to develop a framework that defines the accountability relationship between the Minister of Health and the health authorities. The framework being created is based on that recommended by the Deputy Ministers' Council and the Office of the Auditor General of British Columbia.

It is critical that the ministry continue its efforts to develop performance measures, and that these measures be developed within the context of its vision and strategic direction.

Information for accountability reporting needs to be reviewed

In November 1994, the ministry initiated a project to review health information management across the health system. However, because of the changes in the structure of the system, changes in roles and responsibilities, and the need to set clear performance measures, the ministry needs to reassess its current information and processes to ensure it is collecting the information that will enable it to report on overall performance.

In general, the health authorities we interviewed have not yet defined their information needs. The information currently provided to the governors is structured by service and program. The information varies from authority to authority, but consists mainly of financial and statistical information. Current information systems are fragmented and do not allow for integrated data collection within regions or communities, and many areas do not have the necessary hardware or software to support their information needs.

Current reporting requirements by the health authorities to the ministry and by the Minister to the Legislative Assembly focus mainly on financial information and activities, and not on what outcomes the ministry intends to achieve nor on other aspects of performance. To adequately report on accountability and the result of the regionalization initiative, the ministry, as well as the health authorities, should review the current information systems to determine what needs to be done to ensure the necessary information for reporting is available.

summary of recommendations

The Ministry of Health should communicate its vision for the health system, and should prepare a strategic plan based on that vision to provide clear direction to the health authorities. The ministry should also ensure that the strategic plans prepared by the health authorities are in line with what it wants to achieve.

The Ministry of Health and the Ministry for Children and Families should clarify the relationship of the health authorities with the Ministry for Children and Families, to ensure an integrated, holistic approach to health for children and families is achieved.

The Ministry of Health should further clarify its own roles and responsibilities, as well as those of the health authorities, so that there is a consensus about what the roles and responsibilities are.

The Ministry of Health should review the planning responsibilities of the Community Health Services Societies and the Community Health Councils to ensure that the broader health issues in each region are appropriately addressed, and to ensure there is a coordinated approach for planning across communities.

The governors of the health authorities should conduct annual board evaluations and inform the Minister about the results of such evaluations.

The Ministry of Health and the health authorities should identify the competencies required of individuals to serve on the authorities, as well as the competencies required of the board as a whole; and should establish criteria for selecting members with qualifications to be able to govern effectively.

The Ministry of Health should review the composition of the health authorities in the context of its definition of conflict of interest and take the necessary steps to ensure that conflict of interest issues are dealt with before the next set of appointments.

The Ministry of Health and the health authorities should determine the extent of orientation and training needed by board members and ensure that the needs are met.

The Ministry of Health should continue to develop its performance measurement framework and ensure that it is based on its strategic goals and objectives.

The Ministry of Health should review its current information systems and develop a plan to ensure that the information generated by it and the health authorities will enable the ministry to report on the performance of the health care system.

The Ministry of Health should establish the level and format of reporting it requires to be able to assess the performance of the health authorities, and should ensure that the health authorities report such information.

The Ministry of Health should structure its reporting to be congruent with the accountability framework recommended by the Deputy Ministers' Council and the Office of the Auditor General of British Columbia, and should use this information to provide a comprehensive report to the Legislative Assembly on health and health services in the Province.

Glossary of Terms

Accountability

The obligation to account for responsibilities conferred.

Affiliates

Facilities or agencies that receive their funding through a Regional Health Board or a Community Health Council but retain the right to own, govern and operate services. These facilities or agencies enter into agreements with the health authorities, which outline the relationship between the two in terms of expectations, oversight and delivery of services.

Allocation plan

A plan that the health authorities must submit to the Ministry of Health to show how they intend to use their grant to provide health services in their communities.

Benchmark

A standard or reference point against which something is measured. The term is used in two different ways in the literature: in conjunction with setting of long-term goals for a broad range of societal and economic policies; and as a measure of efficiency in comparing key aspects of an organization's performance with that of similar organizations.

Contracted agencies

Agencies who enter into contracts with the health authorities. These include for-profit agencies, small community-based agencies receiving little funding, and multi-service agencies receiving a small portion of their funds from the Ministry of Health.

Core services

Those health services that must be accessible to all residents of the Province, including:

- locally managed services that will be provided to every region by boards or councils (normally through delivery within the region, but, in special cases, also through the purchase of services outside the region);
- specialized services that will be provided and managed in a limited number of regions under provincial coordination; and
- provincial programs that will continue to be provided and managed by central agencies (including the Ministry of Health).

Determinants of health

Factors outside the health care system that affect peoples' health. Examples include: clean, safe environments; adequate income; meaningful roles in society; good housing, nutrition, education and social support in communities; and access to effective health care services.

Governance

The authoritative direction or control over an entity. Refers to: who is in charge, who sets strategic direction, who makes policy decisions, who monitors progress, and who is accountable for the performance of an entity. The governance framework related to health care includes the Legislative Assembly, the Minister of Health and Minister Responsible for Seniors, and the boards of the health authorities.

Governors
Individuals appointed by the Minister of Health to govern Regional Health Boards, Community Health Councils, and Community Health Services Societies.

Health authorities
Legal entities established by the Ministry of Health under the regionalization initiative: Regional Health Boards, Community Health Councils, and Community Health Services Societies.

Health outcomes
A change in the health of an individual, group of people, or population, which is attributable to an intervention or series of interventions.

Intervention
An action taken to cause an effect or make a diagnosis.

Operational direction
Focuses on an organization's staffing, budget, and resource allocation.

Outputs
Measurable direct results of activities, such as products or services provided (examples: number of teens counseled about teen pregnancies; number of immunizations given; number of surgeries completed).

Regionalization
The creation of regional or local governance structures to direct and integrate the operations of health services.

Standard
An expected level of performance against which actual performance can be compared.

Strategic direction
A clear statement of an organization's mission and vision. Sets goals, objectives and key strategies to address the factors that are essential to the organization's success.

Tertiary care
Care that requires highly specialized skills, technology and support services, such as heart surgery and renal dialysis. Usually provided in facilities serving a large region or the Province as a whole.

Union Board of Health
In the old health care system, a body created under the *Health Act* by two or more municipalities for the purpose of coordinating the administration of health services in the area within their jurisdictions. These bodies were dissolved under the regionalization initiative.

detailed report

background

In 1990, the Royal Commission on Health Care and Costs began an extensive examination of health services in British Columbia. Its goal was to determine how the existing system worked and what had to be done to improve it. It was asked to report its findings and make recommendations with particular respect to structural changes, utilization management, application of technology, funding and reimbursement methods, and ways of achieving service effectiveness and management efficiencies of the health care system.

The commission released its findings in the fall of 1991. It reported a serious lack of direction in health care in the Province, a lack of local influence, and a heavily centralized bureaucracy that separated the system from the people it served and was littered with barriers that reinforced inequities, discouraged initiative and stifled changes. The commission made numerous recommendations on all aspects of the system and identified what it believed were the necessary components of an effective, efficient health care system. These included: operating closer to home, putting the public first, measuring outcomes, involving the community, funding to acceptable levels, breaking down walls to achieve an integrated system (the Jericho process), providing necessary education, supporting volunteers, and increasing openness.

In its terms of reference, the Royal Commission on Health Care and Costs was asked to examine:

- the structure, organization, management and mandate of the current health care system to ensure continued high quality, access and affordability throughout the 1990's and into the 21st century;
- the utilization, appropriateness and efficacy of health care services, including hospital and continuing care services, medical services and prescription drug programs and growth rates in these programs, to identify possible options and efficiencies that would allow for improvements in the quality of care and better cost management;
- the costs associated with each of the health care system's major elements and current methods of funding and reimbursement and to identify possible options, including alternative delivery models, that would allow for better allocation and use of available resources;
- the physician, nursing and other health care professional manpower requirements of the Province of British Columbia;
- the opportunities to further the health of British Columbians through health promotion, health protection and the implementation of healthy public policies; and
- existing legislation to ensure the statutory framework in place is consistent with the achievement of an economical, efficient and effective system of health care and health promotion.

New Directions

Following the release of the Royal Commission's report, the Ministry of Health undertook months of consultation with stakeholders and, in 1992, released *New Directions for a Healthy British Columbia.* This was the ministry's strategic plan for reforming the health system. It outlined a definition of health, a vision for a revitalized health system, and a mission statement to guide the process of change. It also established five priorities, each accompanied with specific actions. Appendix A provides an overview of the New Directions plan.

From 1992 until the spring of 1996, reform proceeded with legislated creation of 20 Regional Health Boards and 82 Community Health Councils, introduction of a labor adjustment strategy, education and orientation of new council and board members, and development of health and management plans by the boards and councils. However, except in one area, the process never advanced to the point of the boards and councils assuming responsibility for the health services within their jurisdictions.

During this period a set of provincial health goals was developed, based on the broad determinants of health, to provide a means of measuring progress over time. In 1994, the role of the Provincial Health Officer was redefined by legislation. The Provincial Health Officer is to report independently to the Minister of Health and directly to the public on health issues, and produce an annual report on the health of British Columbians. Interim health goals were developed and formed the basis of the Provincial Health Officer's Annual Report. In July 1997 Cabinet officially approved the provincial health goals, which the Provincial Health Officer will continue to report on annually (see Exhibit 1).

Achieving these health goals is the responsibility of all government ministries not just the Ministry of Health. To help the ministries in this regard, Health Impact Assessment Guidelines were introduced in 1994 to assess how their policy decisions and programs impact on health.

Then, in June of 1996, in light of a number of serious concerns raised about New Directions, the Minister of Health halted the whole process and assembled a Regionalization Assessment Team, consisting of Members of the Legislative Assembly, to conduct a review. The terms of reference of the team emphasized the need to review the cost-effectiveness of regionalization to ensure it would not affect the quality of health care services currently available in the Province.

The Regionalization Assessment Team submitted its report and recommendations (see Appendix B) to the Minister of Health in the fall of 1996. The Minister accepted the recommendations and announced that New Directions was being reconfigured as "Better Teamwork, Better Care," and that a transfer of responsibility to a specified number of health authorities would occur on April 1, 1997.

Better Teamwork, Better Care

The stated goal of Better Teamwork, Better Care is "to improve health care for people," and its key priorities are:

- ensuring access to the service you need when you need it;
- providing the best possible quality of care;
- keeping hospital lengths-of-stay as long as needed, but as short as possible;
- keeping waitlists as short as possible;
- encouraging and providing innovative new services;
- ensuring patient satisfaction; and
- ensuring that we make the changes needed that will keep our public health care system affordable for the future.

Exhibit 1

Provincial Health Goals

Overall Goal:

To maintain and improve the health of British Columbians by enhancing quality of life and minimizing inequalities in health status. This can be accomplished through:

1. Positive and supportive living and working conditions in all our communities.
2. Opportunities for all individuals to develop and maintain the capacities and skills needed to thrive and meet life's challenges and to make choices that enhance health.
3. A diverse and sustainable physical environment with clean, healthy and safe air, water and land.
4. An effective and efficient health service system that provides equitable access to appropriate services.
5. Improved health for Aboriginal peoples.
6. Reduction of preventable illness, injuries, disabilities and premature deaths.

Source: Provincial Health Officer's Report 1996

The Better Teamwork, Better Care initiative shifted the ministry's focus from health and its broader determinants to health care, which focuses more on services. "Health" and "health care" are two distinct concepts, although health care does have a direct impact on the health of those who are ill. Health refers broadly to the condition of one's well-being physically, mentally and in terms of access to social and personal resources. Whereas health care generally refers to the provision of specific services to treat or prevent particular diseases or conditions.

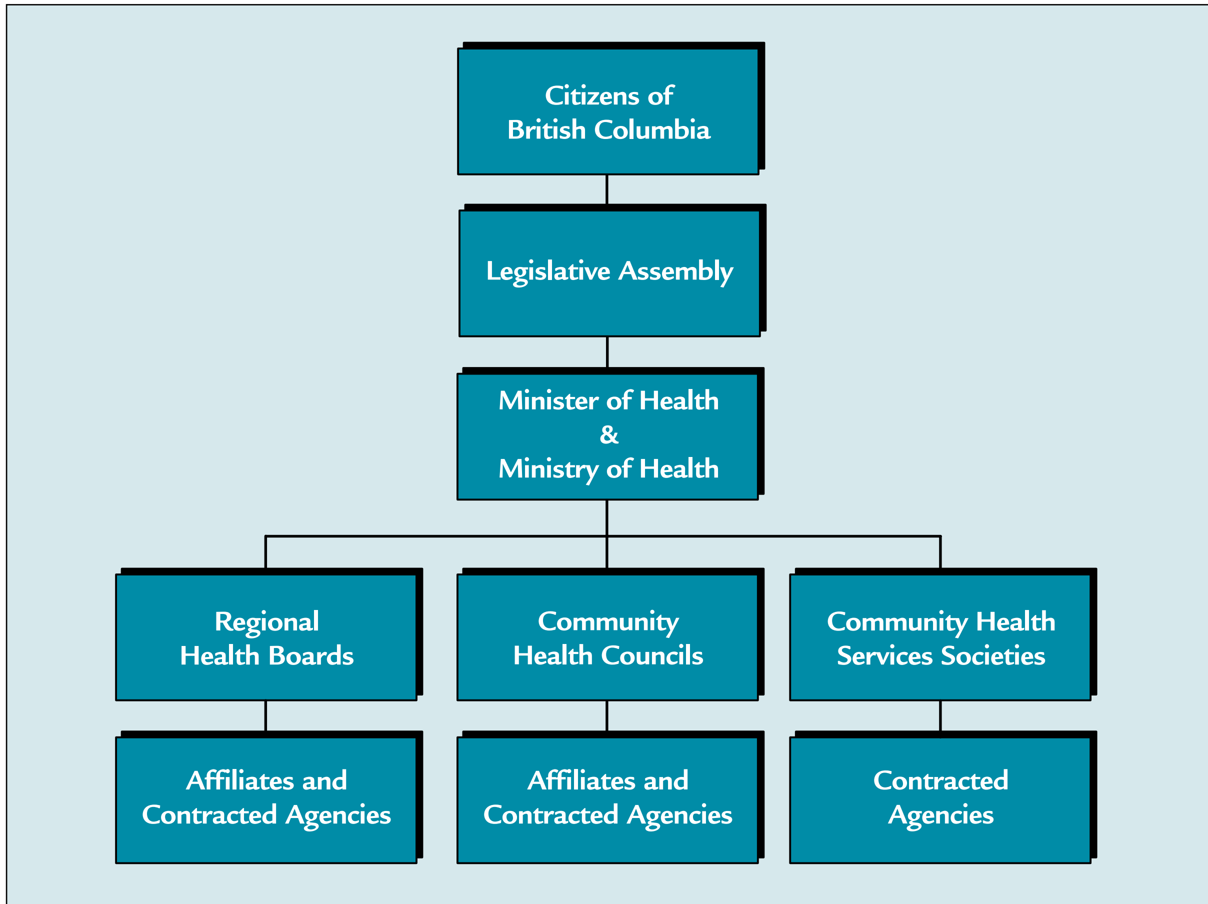
This new initiative kept some of the elements of the New Directions structure, but reduced the number of Regional Health Boards from 20 to 11 and Community Health Councils from 82 to 34. It also eliminated overlap in governance between the two levels: under New Directions, community councils were to report to the regional boards—an approach that would, it was subsequently believed, create unnecessary duplication. As well, the new approach introduced 7 Community Health Services Societies, made up of members from the community councils within a region.

The boards, councils, and societies are each responsible for the delivery of different levels of health care services. The Regional Health Boards are responsible for acute care hospitals, continuing care facilities, and community health programs (public health, community home care nursing, community rehabilitation, case management, health services for community living, and adult mental health). Community Health Council responsibilities are focused on acute care hospitals, continuing care facilities, and home support agencies. The Community Health Services Societies are responsible for providing community health programs (public health, community home care nursing, community rehabilitation, case management, health services for community living, and adult mental health) to a number of communities within a geographic area. All three groups receive their funding from the Ministry of Health and are expected to allocate those funds in accordance with a ministry-approved plan.

Exhibit 2 outlines the current structure of the Better Teamwork, Better Care initiative; Exhibit 3 shows the location of the Regional Health Boards, Exhibit 4 the Community Health Councils and Exhibit 5 the Community Health Services Societies.

Exhibit 2

Structure of the New Health Care System in British Columbia

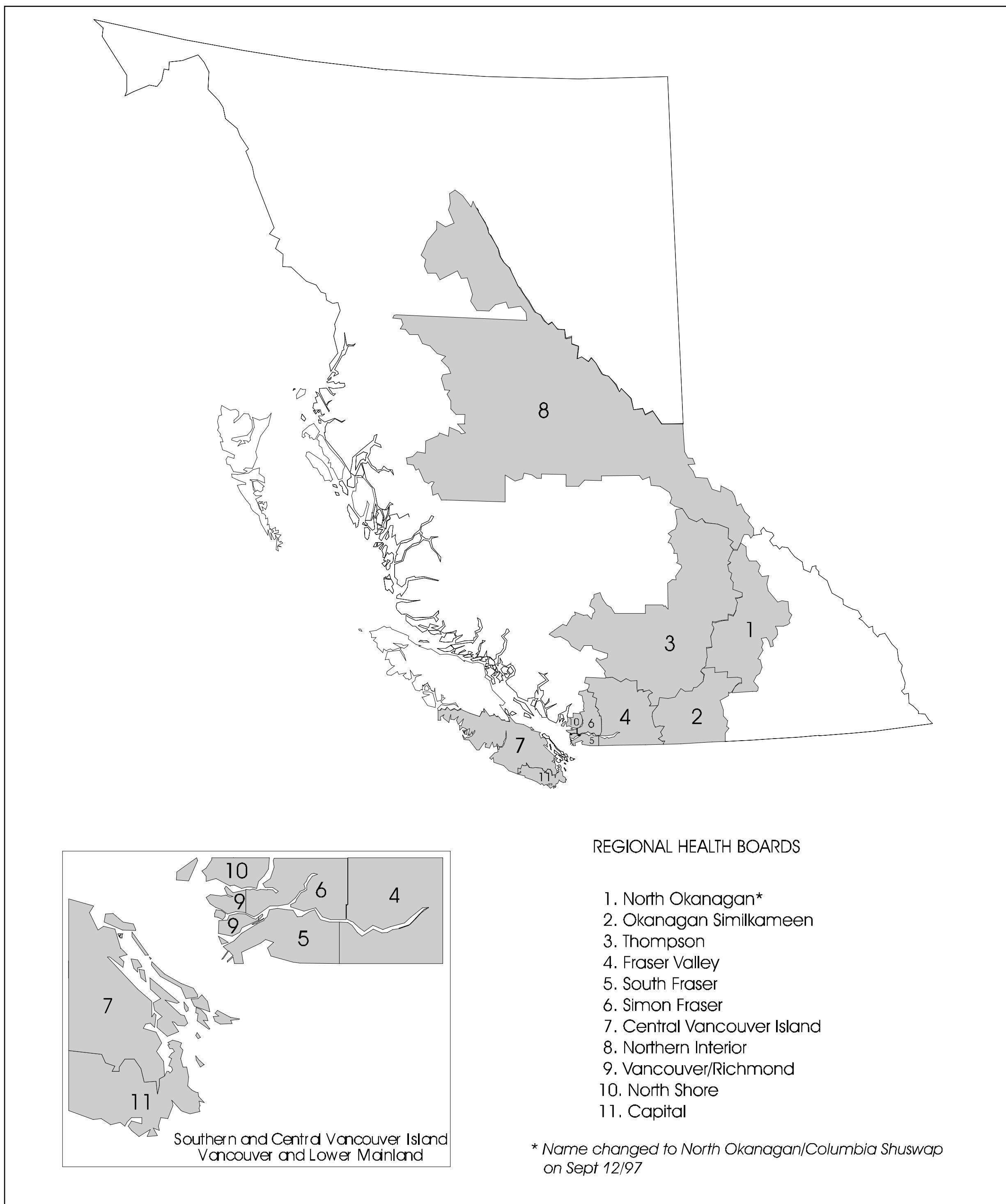


Source: Ministry of Health and Ministry Responsible for Seniors

To prepare for the transfer of responsibility to the 11 Regional Health Boards and as many Community Health Councils as possible on April 1, 1997, the ministry established key implementation tasks, target dates and an implementation project structure. The project structure included the appointment of five Regional Directors, each with a core team consisting of a representative from the ministry's Continuing Care, Acute Care, and Design and Construction divisions. Other team members, such as mental health and public health, were to be added as required.

Exhibit 3

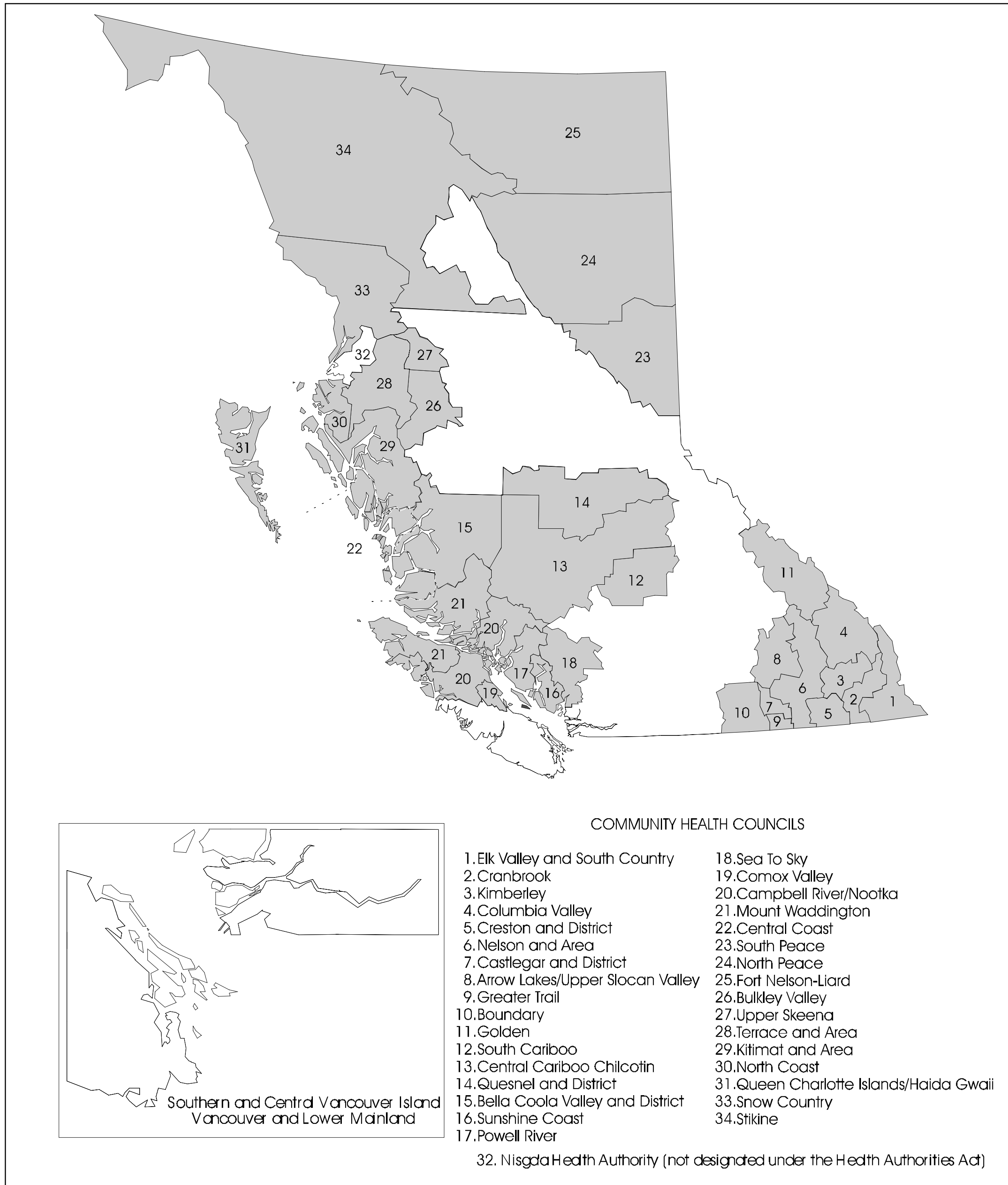
Regional Health Boards



Source: Ministry of Health and Ministry Responsible for Seniors

Exhibit 4

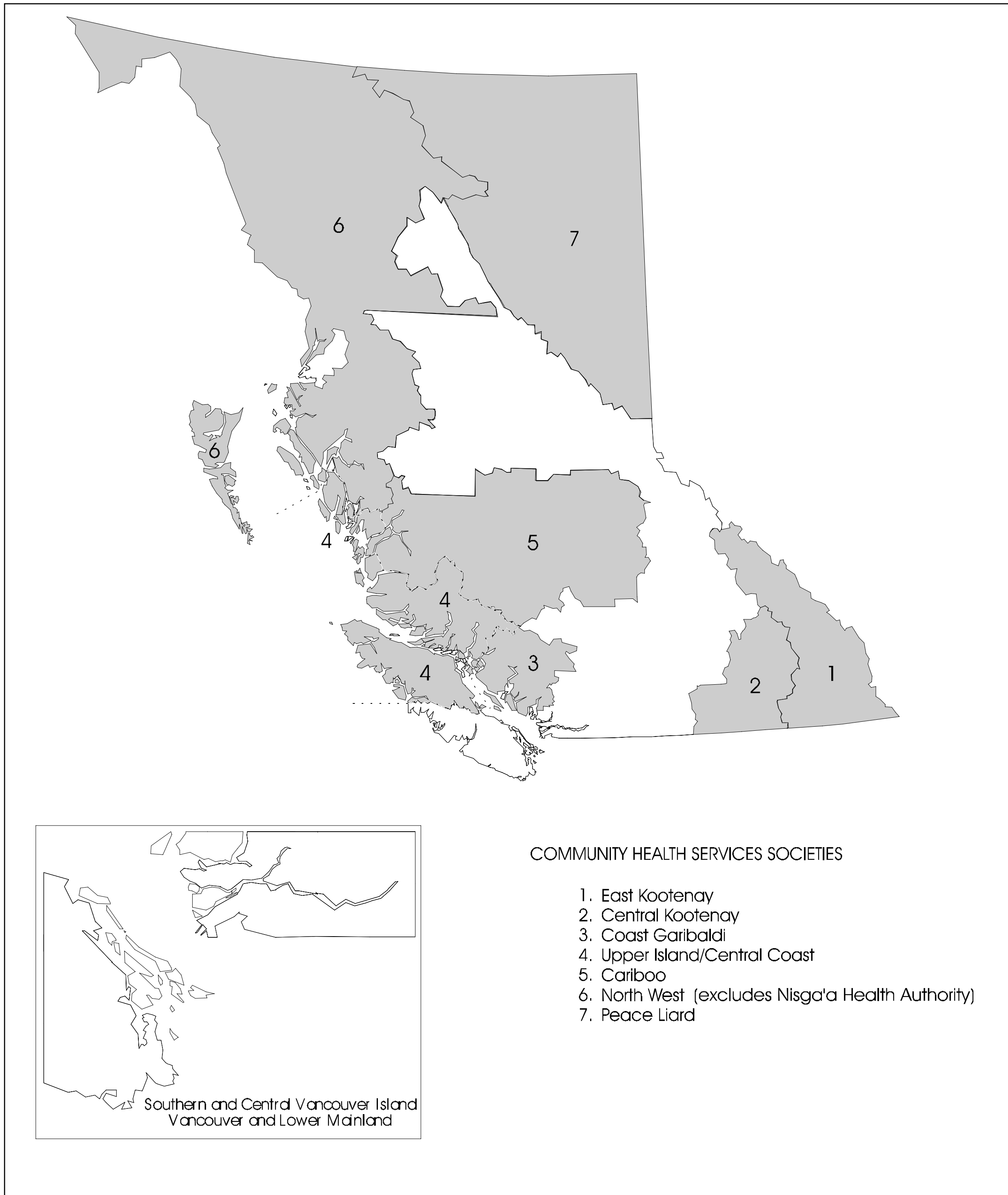
Community Health Councils



Source: Ministry of Health and Ministry Responsible for Seniors

Exhibit 5

Community Health Services Societies



Source: Ministry of Health and Ministry Responsible for Seniors

The Regional Directors and their core teams will continue to function after implementation of the initiative is complete. The job description for their ongoing role was under review at the time of our review. Exhibit 6 lists the implementation work groups and their responsibilities; Exhibit 7 summarizes each of the key implementation tasks and target dates for the initiative (our review focused on the processes in place on April 1,1997 and did not assess whether these target dates were achieved).

Exhibit 6

Ministry of Health Regionalization Initiative: Implementation Work Groups and their Responsibilities

The following work groups were established to assist the regional teams with a wide range of implementation tasks:

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

Legislative: Responsible for drafting Minister's Orders and Orders in Council to facilitate implementation of regionalization. This work group will review any legislative changes required for the long term.

Board Support: Responsible for working with the Minister's office in facilitating the appointment process to Regional Health Boards and Community Health Councils and to provide support to the new boards and councils including training and guidelines for board operations.

Labor Relations: Responsible for negotiating the establishment of transfer agreements for Ministry of Health and Municipal Health Department staff going to regional boards and for ministry staff going to Community Health Services Societies. This work group is also responsible for Chief Executive Officer severance and placement coordination; implementation plan of the Executive and Non-Contract Compensation Program; and management of the process for union representation on regional boards and community councils.

Human Resources: Responsible for overseeing the details involved in implementing the transfer agreements for Ministry of Health staff going to Regional Health Boards or Community Health Services Societies.

Community Health Services Societies: Responsible for developing the operational framework for the societies.

Planning and Accountability: Responsible, through and beyond the Phase II implementation period (which ends March 31, 1997), for developing a process that the ministry can use to audit performance and report annually on performance outcomes. This work group will be a joint ministry and industry committee.

Source: Ministry of Health and Ministry Responsible for Seniors

Exhibit 7

Ministry of Health Regionalization Initiative: Key Implementation Tasks and Target Dates

Target Date	Implementation Task
October 24, 1996	Implementation project structure is put in place, including reactivation of labor relations activities for Ministry of Health staff transfers to health authorities.
November 29, 1996	Minister announces new regionalization initiative.
December 9, 1996	Minister announces the transfer of designated Ministry of Health services to the Ministry for Children and Families. The two ministries begin determining a funding model for devolved shared services.
By December 16, 1996	Minister appoints members to Regional Health Boards.
By December 20, 1996	Template for funding and transfer agreement, including accountability provisions, between Ministry of Health and Regional Health Boards are finalized.
December 1996 to March 31, 1997	Ministry staff develop separate workplans for each Regional Health Board and Community Health Council. Ministry staff assist regional boards and the first group of community councils to become operational by April 1, 1997. The second group of community councils will receive authority on October 1, 1997.
December 1996 to March 15, 1997	Ministry staff develop separate workplans for each Community Health Services Society and assist the organizations to become operational by April 1, 1997.
January 1 to March 15, 1997	The process for completing amalgamations and affiliations proceeds in all Regional Health Boards and Community Health Councils.
By January 15, 1997	Minister of Health appoints members to Community Health Councils.
January 1997	Legislative changes required to facilitate long term implementation of regionalization are submitted.
By January 31, 1997	Template for funding and transfer agreement, including accountability provisions, between Ministry of Health, first group of Community Health Councils and Community Health Services Societies are finalized.
January 31, 1997	Designated Ministry of Health services transfer to Ministry for Children and Families.
March 1, 1997	All funding and transfer agreements for Regional Health Boards, Community Health Services Societies, and the first group of Community Health Councils completed and ready for implementation on April 1, 1997.
March 15, 1997	Required amalgamations are completed in Regional Health Boards and first group of Community Health Councils.
April 1997	Legislative changes to the *Health Authorities Act* and related statutes are introduced in the Legislature.
April 1, 1997	All Regional Health Boards and specified Community Health Councils receive governance authority, Community Health Services Societies become operational.
April 1, 1997	Proposed date on which Union Boards of Health will dissolve and new health authorities assume their responsibilities.
On or before April 1, 1997	Ministry of Health service provider staff transfer to new employer—Regional Health Boards or Community Health Services Societies—depending on where they are located in the Province.
April 1, 1997	Implementation project concludes. Ministry of Health regional organization assumes full responsibility for finalization of remaining implementation goals and regular delivery of program activities.
April 2 to September 30, 1997	Ministry staff assist second group of Community Health Councils to become operational by October 1, 1997.

Source: Ministry of Health and Ministry Responsible for Seniors

As a result of the transfer of health services to the health authorities, the latter have assumed responsibility for about $4 billion of annual expenditures, which represents more than half of the total health budget. Exhibit 8 indicates how total health funding is allocated among the health authorities and ministry programs.

Exhibit 8

Health Funding for the Fiscal Year Ending March 31, 1998

Expenditure Area	Estimated Expenditures In $ millions	% of Total Expenditures
Regional Health Boards	$3,495	49
Community Health Councils	343	5
Community Health Services Societies	86	1
Total for health authorities	3,924	55
Ministry of Health programs	3,252	45
Total budget for ministry	$7,176	100

Source: Ministry of Health and Province of British Columbia Estimates

direction provided by the ministry of health to the health authorities

One of the key roles of the Ministry of Health is to provide leadership through a clear vision of health reform—a vision that provides the basis for the ministry's strategic plan, and a framework on which the health authorities in turn can develop a vision for health care in their communities. Only by having this type of clear direction can the parties evaluate the extent to which they are accomplishing their goals.

Conclusion

The Ministry of Health's vision for Better Teamwork, Better Care has not been as well communicated as it needs to be, and the ministry has not yet developed a strategic plan based on its vision. The health authorities need to have a clear sense of what the ministry intends to accomplish, before they can set their own strategic direction.

The relationship of the health authorities with the Ministry for Children and Families also needs to be further clarified to ensure an integrated and holistic approach to health for children and families.

Strategic Direction

The goal of Better Teamwork, Better Care is *to improve health care for people.* This goal refocuses the system from health in its broader context to health care, a service-based approach. What the Ministry of Health has not communicated to the health authorities, however, is whether its earlier vision of *healthy individuals and healthy communities* is still a priority and, if it is, how it links to the goal of Better Teamwork, Better Care. Also the ministry has not clearly stated how the Provincial Health Goals with their basis in the broad determinants of health are linked to the priorities of Better Teamwork, Better Care. Nor has the ministry clearly stated whether the health authorities are expected to integrate these goals into their strategic planning. However, the Provincial Health Officer, in his 1996 annual report, envisions a role for the health authorities linking both health and health services. The report states " To make improvements in health, boards, councils, and societies will need to ensure the best possible health services are provided. The health authorities can also take on a coordinating or advocacy role for cross-sectoral

activities aimed at improving health such as programs to decrease poverty, increase education levels, and so on. As well they can influence the development of healthy public policy."

The lack of clarity around these issues creates a significant gap because it affects what services the health authorities plan to provide in their communities, how the ministry allows them to use their funds, and how performance criteria will be defined.

The connection between future funding and the new health care priorities is another uncertainty. In fact, the ministry continues, in conjunction with the health care industry, to plan for the implementation of a population-based funding model (which takes into account age, health status and cost of delivering services). Such a model is more compatible with a focus on health than with one on services consumed.

The health authorities we interviewed for this review told us that although they generally understand the essence of Better Teamwork, Better Care and the need for integration and efficiencies, without clear direction they remain more focused on the concept of healthy individuals and healthy communities.

Funding and Transfer Agreement

The Funding and Transfer Agreement is the contract between each individual health authority and the Province of British Columbia, represented by the Minister of Health. These contracts do not provide strategic direction, but rather broad operational direction, imposing conditions on the funding of the authorities, setting out their obligations, and defining the duties, powers and functions delegated under specific Acts.

The agreements of the regional boards state that they must deliver health services as set out in the Core Services Report (Exhibit 9) and allocate and disburse their grants in accordance with their Allocation Plans (as approved by the Province). Under their agreements, the councils and societies must provide health services as required by the Province and also allocate and disburse their grants in accordance with the Allocation Plans.

Health and Management Plans

Health and Management Plans were developed under New Directions in accordance with ministry guidelines. These plans were to assist the boards and councils in the transition from a centralized health system to one that is regionalized. The plans were to reflect the unique needs of each community,

Exhibit 9

Ministry of Health Core Services Report: Categories and Components

Population Health

- Community Health Assessment
- Health Promotion
- Health Protection
  - Mandated environmental health protection services
  - Community care facilities
  - Communicable disease control

Personal Health

- Prevention and Public Health Services
  - Prevention of injury, non-communicable disease and substance misuse
  - Wellness
  - School health
  - Reproductive health
  - Dental health
  - Nutrition
  - Hearing
  - Speech/language
- Treatment (acute and chronic care)
- Development, Rehabilitation and Support Services
  - Rehabilitation therapy
  - Early childhood intervention
- Palliative Care
- Home Based Care
  - Home support and other support services
  - Clinical care
  - Respite
  - Care coordination
- Residential Care
  - Residential care options
  - Residential care options for special populations
- Mental Health Services
  - Clinical services
  - Support, psychosocial rehabilitation and outreach
  - Emergency response and short-term intervention
- Substance Misuse Services
  - Detoxification
  - Treatment
  - Support

Source: Ministry of Health, July 1994, Core Services Report, Table 1

but were to be in keeping with the vision, mission, strategic direction, and core service requirements of the ministry.

The Health and Management Plans remain the guiding documents for the Regional Health Boards. The Funding and Transfer Agreements state that "the authorities shall use their best efforts to implement the Health & Management Plans." The agreements of the Community Health Councils make no reference to the Councils being required to implement their plans.

As newly created entities, the Community Health Services Societies do not currently have Health and Management Plans, although there is an expectation that they will develop them.

Of the existing Health and Management Plans of the boards and councils we interviewed, we found that all reflected the New Directions vision of healthy individuals and healthy communities. Two of the authorities have updated their plans to reflect the need for the efficiencies and integration of Better Teamwork, Better Care—but those plans also continue to focus on improving community health.

Relationship with the Ministry for Children and Families

The Ministry for Children and Families was created in 1996 as a result of the findings of the Gove Inquiry into Child Protection in British Columbia. The Inquiry recommended that provincial responsibility for all child welfare services (then scattered throughout numerous ministries) be brought together in this single new ministry.

Ministry of Health programs transferred to the Ministry for Children and Families included public health (speech, audiology, nutrition and dental), public health nursing services relating to children and youth, forensic psychiatric services related to children and youth (e.g., Maples, Family Court Center and Youth Court Services), child and youth mental health services, infant and child development programs, and all alcohol and drug programs. This reorganization has required the establishment of new relationships between the two ministries, as well as between the new ministry and the Regional Health Boards and Community Health Services Societies.

The Ministry of Health and the Ministry for Children and Families signed a Memorandum of Understanding, which dealt with the transfer of resources and program records between the two ministries. It did not address the new roles and responsibilities of the two ministries and the health authorities.

The Ministry for Children and Families is the lead agency in setting policy direction for those programs transferred to it from the Ministry of Health; and the Ministry of Health is the lead in managing overall funding and the contract process with the health authorities. The primary contact for the health authorities in the Ministry for Children and Families is the Regional Operating Officer, who is responsible for ensuring that the priorities and issues of children, youth, and families are included in discussions and negotiations with the health authorities. In the Ministry of Health, the primary contacts for the health authorities are the Regional Directors, who in turn have access to a manager from the Public and Preventive Health Division.

The Funding and Transfer Agreement between the Province and each health authority covers all services, including those provided under the Ministry for Children and Families. The budget letters to the health authorities from the Ministry of Health outline the dollars that are allocated to the programs of the Ministry for Children and Families. When they receive their budget letters, the health authorities must submit funding allocation plans to the Ministry of Health for approval. The Regional Operating Officers and the Public and Preventive Health Managers are responsible for reviewing the section of the plans relevant to them, before the entire plan is signed off by the Ministry of Health.

A number of the boards and societies we interviewed stated that the roles and responsibilities of the Ministry for Children and Families need to be clarified. Some also stated that, for those programs under the Ministry for Children and Families, they are not clear to whom and for what they are accountable. At the same time, however, several authorities acknowledged that these new relationships will take time to sort out.

Recommendations

The Ministry of Health should communicate its vision for the health system, and should prepare a strategic plan based on that vision to provide clear direction to the health authorities. The ministry should also ensure that the strategic plans prepared by the health authorities are in line with what it wants to achieve.

The Ministry of Health and the Ministry for Children and Families should clarify the relationship of the health authorities with the Ministry for Children and Families, to ensure an integrated, holistic approach to health for children and families is achieved.

roles and responsibilities

Governing bodies, in both the private and public sectors, fulfill three roles to meet their mandates and responsibilities: policy formulation, decision-making and oversight. The key responsibilities are setting strategic direction and ensuring effective executive, organizational, and board performance.

The health care environment is complex and involves many stakeholders who have various roles and responsibilities in providing the effective functioning of the system. For the purposes of this review, we focused on the roles and responsibilities of the Ministry of Health, the health authorities and the Ministry for Children and Families. Given the complexity of the health care environment, the roles and responsibilities of these bodies must be clearly defined, flow logically from the overall direction of the ministry, be congruent with that direction, and be understood by those who must fulfill them.

Conclusion

The health authorities we visited have a general understanding of their roles and responsibilities. However, we found that some are confused about the boundaries of their authority, and in particular they do not have a clear understanding of what types of decisions require ministry approval prior to implementation.

In areas of the Province where there are Community Health Services Societies and Community Health Councils, there is a vacuum in regional planning which may limit the ability of the ministry to achieve what is intended. No one body is designated to ensure that planning for health services across and between communities is coordinated and that it provides efficiencies.

Setting Out Roles and Responsibilities

Legislation

The *Health Authorities Act* of 1993 created the first stage in the establishment of Regional Health Boards and Community Health Councils across British Columbia. The Act, with its subsequent amendments in 1995 and 1997, broadly defines the responsibilities of the boards and councils (summarized in Exhibit 10), as well as of the Minister of Health. The *Ministry of Health Act* further defines the responsibilities of the Minister and the Ministry of Health generally.

Exhibit 10

Responsibilities of Regional Health Boards and Community Health Councils

Responsibility	Regional Health Boards	Community Health Councils
Planning	To develop and implement a regional health plan that includes: ■ the health services provided in the region, or in part of the region, ■ the type, size and location of facilities in the region, ■ the programs for the delivery of health services provided in the region, ■ the human resource requirements under the regional health plan, and ■ the making of reports by the board to the Minister on the activities of the board in carrying out its purposes.	To develop a community health plan that specifies and provides for: ■ the delivery of health services in the community, and ■ the making of reports by the council to the Minister on the activities of the council in carrying out its purposes.
Policy and Allocating Resources	To develop policies, set priorities, prepare and submit budgets to the Minister and allocate resources for the delivery of health services, in the region, under the regional plan.	To project future need for health services, set priorities, prepare and submit budgets to the Minister for the delivery of health services in the community in which the council was established, and allocate resources for the delivery of health services in that community.
Administration of Funds	To administer, and allocate grants made by the Provincial government for the provision of health services in the region.	To administer and allocate grants made by the Provincial government for the provision of health services in the community for which the council was established.
Service Delivery	To deliver regional services through its employees or to enter into agreements with the government or other public or private bodies for the delivery of those services by those bodies.	To coordinate and integrate health services in the community: deliver those services through its employees, or enter into agreements with the government or other public or private bodies for the delivery of those services by those bodies; and operate hospitals and other facilities.
Standards Development and Evaluation	To develop and implement regional standards for the delivery of health services in the region; monitor, evaluate and comply with Provincial and regional standards and to ensure delivery of specific services applicable to the region. In carrying out its purposes, a board must give due regard to the Provincial standards and specified services.	To develop and implement community standards for the delivery of health services in the community: monitor, evaluate and comply with Provincial and community standards; and deliver specified services applicable to the community. In carrying out its purposes, a council must give due regard to the Provincial standards and specified services.
Act as a Community Health Council	To exercise the powers and perform the duties of a council in those parts of the region for which there is not a council established under this Act.	
Reporting	To report to the Minister on the activities of the board in carrying out its purposes.	To report to the Minister on the activities of the council in carrying out its purposes.

Source: *Health Authorities Act* of 1993 and subsequent amendments of 1995 and 1997

As laid out in the *Health Authorities Act,* the Minister of Health is responsible for establishing provincial standards for the provision of health services, specifying the types and levels of service that must be provided in a region or community, and ensuring that, once grants are allocated, boards and councils comply with applicable regulations. The Minister must also ensure that health services continue to be provided on a predominant not-for-profit basis, and that the services continue to meet the criteria of the *Canada Health Act* (those governing public administration, comprehensiveness, universality, portability and accessibility).

Under the *Ministry of Health Act,* the Minister also has the right to delegate any or all of his or her duties, powers and functions. As well, the Act gives to the Ministry of Health, under the direction of the Minister, responsibility for all matters related to public health and government-operated insurance programs.

The Community Health Services Societies were created under the *Society Act.* This Act does not provide any description of the responsibilities specific to these bodies.

Directive Documents

We found that various documents outlining the roles and responsibilities of the boards and councils are in keeping with the broad purposes in the *Health Authorities Act.*

A ministry background paper on the Community Health Services Societies is the main source we found that lays out their roles and responsibilities. The societies' role is "to provide a coordinated service delivery structure for specific community health programs, in those areas of the Province which do not have a Regional Health Board." Their responsibilities, according to the paper, are to:

- "employ staff, govern, manage, and deliver public health and community health programs currently delivered by the health unit;
- employ staff, govern, manage, and deliver adult mental health programs currently provided through local mental health delivery units;
- employ staff, govern, manage, and deliver Community Home Care Nursing, Community Rehabilitation, Case Management and Health Services for Community Living;
- participate with the Ministry of Health in province wide discussions regarding programs directly delivered by the Societies;

- participate in joint health planning with Community Health Councils as equal partners;
- participate in joint initiatives with the Community Health Councils; and
- deliver Ministry for Children and Families' programs specified in the service agreement."

The Funding and Transfer Agreements are the other documents that define the obligations of the health authorities. One of the obligations is that the authorities must comply with requirements established by the Province for managing and delivering health services. At the time of our review, however, these requirements had yet to be stipulated. The agreements signed with the Regional Health Boards provide for boards to consult with the ministry before any such requirements are established; agreements signed with the Community Health Councils and Community Health Services Societies do not.

Understanding of Roles and Responsibilities

The health authorities we interviewed have a general understanding of their roles and responsibilities. However, some are confused about the boundaries of their authority, not knowing clearly what types of decisions require ministry approval before implementation.

We also found a general consensus among those authorities we interviewed that they have limited ability to act in this current fiscal year (1997/98). The reason they gave is that funding has been allocated by program, and the ministry has set restrictions on how funds can be reallocated among programs. However, the authorities we spoke to also felt that increased flexibility will come in subsequent years.

Guidance from the Ministry

To facilitate the implementation of Better Teamwork, Better Care, the ministry established regional teams led by a Regional Director. These are intended to provide "one-stop-shopping" for the health authorities—that is, they are supposed to respond to questions and concerns they receive from health authorities and, where they can't, to find someone who can.

We found in our review that, although the Regional Directors understood their roles and responsibilities, it had not been clearly established how they should be carried out. Also, the Regional Directors and their teams did not have all the information they needed to answer questions from the authorities, nor did they have clear decision-making authority. This lack of clarity about the roles and responsibilities was

frustrating for the health authorities. Chairs and Chief Executive Officers we interviewed stated that, when seeking guidance or answers, they currently go to where they feel they can get the answers or decisions made–usually the Assistant Deputy Minister or Deputy Minister. The ministry is now in the process of reviewing the roles, responsibilities and authority of the Regional Directors to address this problem.

Of all the authorities we interviewed, the Community Health Services Societies expressed the greatest concern about the lack of support provided them to get established. They were also unclear about what planning responsibilities were theirs and which were the Community Health Councils'. The societies and two of the three councils we interviewed felt that, in areas without regional health boards there is a potential for problems with the current structure. Such problems include the lack of a regional planning process for acute and continuing care services, lack of a coordinated approach to planning when no one body is mandated that role, increased competition and fragmentation of services across communities, and decreased opportunity to create efficiencies.

The *Health Authorities Act* states that each Community Health Council has the responsibility for developing a community health plan and integrating services in the community. However, it is not clear if the Act is referring to only the services that the Community Health Council is responsible for or to all services in the community. If it is the latter, responsibilities would overlap with those of the Community Health Services Societies. Even ministry documents are unclear about the planning responsibilities of the societies for the services they govern, stating that they are to participate in joint health planning with Community Health Councils as equal partners rather than taking the lead in the process.

Governors' Responsibilities

A key responsibility of governors is to set the strategic direction of an organization. Those interviewed for our review recognized this and some were in the initial stages of planning for the development of their strategic plans.

Another important responsibility of governors is to ensure high levels of executive management performance. Fulfilling this responsibility usually entails hiring the Chief Executive Officer, defining the roles and responsibilities of the position, evaluating performance, determining the level of compensation, and terminating employment if the need arises. Under the current system, however, the governors are not in full control of executive compensation.

The boards and councils we spoke with either hired the CEO directly or affirmed the previous appointee. For the societies, it was different. The ministry appointed an interim senior manager for each society. At the time of our review, not all of those appointments had been confirmed as permanent by the individual authorities.

We found that the terms of compensation and severance for the CEO are clearly defined in the Financial Management Policy Manual for Regional Health Authorities, issued by the Ministry of Health. Compensation must be in compliance with the *Health Care Compensation Reference Plan* and the Minister must approve the compensation and severance terms before an offer of employment is presented.

What is not well defined is the need to conduct board evaluations on a regular basis. All the health authorities we interviewed expressed an understanding of the importance of conducting performance evaluations, but only 2 out of the 12 authorities told us they have written policies in place calling for an annual evaluation of board performance.

CEO Roles and Responsibilities

At the time of our review, not all the CEOs we interviewed had a written description of their position's roles and responsibilities. However, most felt they had a good sense of what these were, and of what their board's expectations were. Some authorities have adopted policies to set the limits of the CEO's responsibilities.

Recommendations

The Ministry of Health should further clarify its own roles and responsibilities, as well as those of the health authorities, so that there is a consensus about what the roles and responsibilities are.

The Ministry of Health should review the planning responsibilities of the Community Health Services Societies and the Community Health Councils to ensure that the broader health issues in each region are appropriately addressed, and to ensure there is a coordinated approach for planning across communities.

The governors of the health authorities should conduct annual board evaluations and inform the Minister about the results of such evaluations.

Role of Health Authorities in Other Jurisdictions

A recent survey of accountability legislation in the health sector (conducted by CCAF-FCVI Inc., a Canadian research and educational foundation) found that: "across Canada, health boards do not decide policy issues such as entitlements. The legislated duties of these boards reflect health promotion, and administrative management responsibilities for service delivery under standards set provincially by the minister. They make administrative decisions within funding limits set by the provincial health departments. In some cases, a larger role seems implied by the legislation, such as Alberta's Regional Health Authorities Act that includes the term 'final authority' with respect to certain of the regional authorities' functions. But, in most cases, the duties of the regional boards cluster around health promotion, assessment and prioritizing within regions, and within funding ceilings and policy directives set by the minister. Thus, district or regional boards can be considered in general more as administrative management boards than as 'directing mind' boards that decide policy on such matters as health service levels and who is entitled to what services." At the time of the survey, the information from British Columbia was limited because the review of the Regionalization Assessment Team was under way. However, we think that the findings are the same for British Columbia.

Appendix F provides the summary findings of the survey. Appendix G shows the number and composition of Regional/District health boards across Canada.

Source: Background Report—A Survey of Accountability Legislation in the Health Sector, CCAF-FCVI Inc.

recruitment, selection and appointment to health authority boards

The regionalization of health service delivery in the Province has given the health authorities in British Columbia significant responsibility. As already noted, they are now accountable for more than half of the annual budget of the Ministry of Health. The magnitude of this responsibility highlights the need for the ministry to ensure that the best possible people are recruited, selected and appointed to govern the health authorities.

Conclusion

The process for recruiting, selecting and appointing candidates to the health authorities attempts to ensure that the candidates selected satisfy certain requirements such as those related to geographic representation and equity (e.g. gender, ethnic communities). However, the ministry could improve the process by identifying the necessary competencies required of individual governors and specifying the appropriate composition for each authority as a whole. The formal process used by one regional board to encourage broad public participation and select well-qualified individuals offers a good model.

Authorities need to ensure that all newly-appointed governors are provided with orientation and training to help them understand their roles and responsibilities, as well as those of other key stakeholders.

Importance of Appointing Qualified People to Health Authority Board Positions

In December 1996, our office issued a report on the results of our review of governance in Crown corporations. In that report, we said:

"Governance is enhanced when boards can demonstrate they have the mix of skills and experience necessary to carry out their responsibilities effectively. We believe 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 applicants or nominees against objective criteria; and
- selected from the applicants the person most likely to be an effective member of the board."

The importance of the appointment process as a key step towards effective governance was also mentioned by the Auditor General of Canada in his 1993 report to Parliament: "the demands on board members are onerous and only appointments of the best qualified people can ensure the board's proper functioning."

The Process

Since many of the boards had been previously established under New Directions, the main goal of the recruitment and selection process for Better Teamwork, Better Care was to have as little disruption as possible. The idea was that where there were well-functioning boards or councils, minimal changes would be made. However, where boards or councils were not functioning well, or there was an imbalance in gender or geographic distribution, or specific skills were identified as missing, changes would be made as necessary.

The Office of Agencies, Boards and Commissions, established in April 1992, to assist all ministries and Crown corporations in the selection of candidates for appointments to agencies, boards and commissions, played a consultative role in the recruitment and selection process undertaken for the new initiative. Where changes were to occur in the composition of a board or council, the office's following four principles were to be applied:

- appointments are based on appropriate qualifications and a desire to serve the public interest;
- boards should reflect the population of the Province, including adequate representation by both women and men, ethnic communities, visible minorities, Aboriginal people and people with disability;
- boards should include a mix of business, labour, professional, community and regional interests; and
- the size of the board should reflect the least number of members that can adequately perform the function of that agency, board or commission.

In addition to the principles noted above, experience in managing large sums of money was also considered important. Ministry of Health documents announcing Better Teamwork, Better Care stated that the appointment process "was to place healthcare decision-making in the hands of people reflecting a

broad range of skills, interests, and experience within the communities and regions they serve." At the time of the Better Teamwork Better Care announcement the Minister also indicated that in the future some formal process of local nominations would likely be pursued.

Recruitment

The names of prospective candidates, accompanied by a biographical summary, were submitted to the Minister's office from a variety of sources: existing health authorities, individuals, organizations, and local Members of the Legislative Assembly. We noted that one of the health authorities we visited during our review had a formal public process to allow interested parties to put their names forward. (In this area a committee of non-board members was established and given the responsibility of recruiting potential candidates for appointment to the board. They advertised for interested people, short-listed the applicants according to set criteria, interviewed the applicants, and selected those they then recommended to the Minister for consideration and appointment.)

We reviewed all the biographical summaries submitted to the Minister's office, but were unable to develop profiles of the authorities because many of the summaries were incomplete. At the time of our review, there were 510 board members in total, 164 on regional health boards and 416 on community councils. Forty-two of the council members were also members of the societies. We did note that over half of the appointments were made from those serving on previous Regional Health Boards or Community Health Councils and that most of those appointed have some health board, other sector board, or related experience.

Selection

The selection and appointment process was handled through the office of the Minister of Health. We found no documentation to describe how the principles of the Office of Agencies, Boards and Commissions were to be followed or how a balance of various designated groups (e.g., by age, gender and ethnicity) was to be achieved for each authority. There was also no documentation to identify the competencies required by each individual or by the governing body as a whole. In most cases, potential candidates were not interviewed to assess their abilities to govern effectively.

We also looked for, but did not find, written selection criteria for assessing the qualifications and experience of the

candidates for the position of Chair of each authority. We were told that selection was based on an individual having relevant experience on a previous Regional Health Board or Community Health Council, as well as having leadership skills. There was limited consultation with other governors during the selection process for the position of Chair.

Members of Community Health Services Society boards are selected from the Community Health Council governors within the geographic area that each society serves. Again, we found that the selection of these members was not based on written selection criteria, although we were told that prior membership on a Union Board of Health was considered an asset.

Appointment

In accordance with the *Health Authorities Act,* the Minister appoints members of the Regional Health Boards and Community Health Councils. The Minister also makes appointments to the Community Health Services Societies.

The Act also states that the Chair of a board or council can be designated by the Minister, or elected under the bylaws of the board or council. Under the Better Teamwork, Better Care initiative the Minister appointed the Chairs of all the health authorities, including the Community Health Services Societies.

Most of the Chairs we interviewed felt that the governors reflected the communities that the authority served. Some, however, noted that a number of important skills (such as finance, business and legal) were missing.

Health Care Providers on Regional Boards and Community Health Councils

The Regionalization Assessment Team identified health care providers as being one of the keys to achieving cost control in the delivery of health services, and stressed that their views be considered in health care design and delivery.

The Assessment Team recommended that "the Minister consider providing physicians and unionized health care providers a vote on the governing bodies of the regional health care authorities." Based on this recommendation, the Minister appointed a physician and union representative to each Regional Health Board and Community Health Council as governors. Ministry documents state that this was done "to ensure the expertise and input of those on the frontlines of the

health care system are reflected." No similar recommendation was made for the appointment of a physician or union representative to the Community Health Services Societies.

The ministry's *Financial Management Policy Manual for Health Authorities* (draft) refer the governors to a document titled *Eligibility Criteria and Guidelines for Conduct of Regional Health Boards and Community Health Council Members (1995).* The eligibility criteria state that the following persons are not eligible for membership on a Regional Health Board or Community Health Council:

- "Employees or salaried officers of providers or agencies that receive significant (more than 50%) and ongoing funding from a Community Health Council or Regional Health Board;
- Employees or salaried officers of a Community Health Council or Regional Health Board;
- Independent contractors, or their employees, who are directly funded by the Ministry of Health. These persons would include physicians and other providers who are funded by the Medical Services Plan, pharmacists, and providers and/or agencies funded directly by the ministry of Health program areas."

The document goes on to state that health authorities must develop standards of conduct for their employees, as well as standards of conduct policies and procedures relating to fair business practices. It also highlights the duties of integrity, loyalty, diligence, confidentiality and prudence that the authorities must follow in the conduct of their affairs. As well, the document defines a conflict of interest as follows: "A conflict of interest arises when a Council or Board member's personal and/or business/occupational/professional interests competes with or supercedes his or her dedication to the interests of the Council or Board. This could arise from a real or apparent conflict of interest for a Board or Council member."

The bylaws of the Community Health Services Societies also address the issue of conflict of interest, noting that Directors are not in a conflict of interest when dealing with issues relating to the Community Health Council of which they are a member.

Some of those we interviewed expressed concern that there is an inherent conflict of interest in having a physician and union representative on each board and council, appointments already made by the Minister. Our review of the biographies of those appointed to the health authorities showed that some authorities appear to have additional health

care providers as governors, over and above the physician and union representative appointees.

There is a need by both the ministry and the health authorities to review the conflict of interest issue and ensure that it is appropriately dealt with before the next set of appointments is made.

Compensation for Governors

Unpaid volunteers have always provided governance to the health system. In keeping with this philosophy, one of the recommendations of the Regionalization Assessment Team, and one adopted by the Minister, was that there be no remuneration for individuals who sit on Regional Health Boards or Community Health Councils. However, because the boards and societies draw their membership from a broad area, concern was expressed by some of the authorities we interviewed about the "no wage replacement" policy. They felt that because of the policy, not all members of the community could participate in the recruitment process. For example, it was suggested that those who knew they could not afford to take unpaid time from work if they were appointed would not even put their names forward. The policy may also have prevented some current members from regularly attending meetings, especially when they had to travel distances that required time off work.

These concerns may need to be looked at in the interests of maintaining the values of equity and community participation.

Orientation and Training

Effective governance requires a competent board. Board members control significant resources consisting of assets and employees. Their decisions affect not only the health authorities themselves, but also the communities they serve. To be able to do their jobs effectively, they have to be provided with suitable orientation to their environment and adequate training as to how best to carry out their responsibilities.

Under New Directions, the Ministry of Health played a lead role in providing governors with an extensive orientation on their roles and responsibilities, as well as on other topics important to effective governance. With the shift to Better Teamwork, Better Care, the ministry withdrew from educating authorities directly, which some feel has left a vacuum. The ministry acknowledges the importance of training for governors, and even canvassed the health authorities in early April 1997 to inquire about their education needs. It found that the needs

vary considerably among the authorities, but has taken no further action since its decision not to be a provider of education.

The British Columbia Health Association, an independent, non-government, non-profit group, has historically provided orientation sessions to governors. However, such sessions were in abeyance at the time of our review while the future of the organization was being decided by the membership. The association also used to publish the Resource Guide for Health Governors, which covered a wide variety of topics such as delegation of authority, resource management, legal responsibilities, models of governance, and funding of health services. It was not clear at the time of our review whether this publication would continue to be issued.

Although the health authorities have received limited ministry guidance about education and training since their appointments, most of those we interviewed had already held (or were planning to hold) their own education and orientation sessions. Topics covered include roles and responsibilities, governance, the budget process and an introduction to the health services within the local jurisdiction. Some of the authorities also continue to use the Resource Guide for Health Governors as an educational tool.

We found that the authorities we interviewed were using a number of different models of governance. Most authorities were implementing a policy-based approach referred to as the Carver model. It does not use a committee structure to operate; instead, all work and decisions are by the whole board. Other authorities were following a modified version of this model, or a different approach called the committee-type model.

All the health authorities we interviewed recognized that education is an ongoing need. Areas they identified as requiring continuing education included governance, roles of other stakeholders, performance, and outcome measurements.

Recommendations

The Ministry of Health and the health authorities should identify the competencies required of individuals to serve on the authorities, as well as the competencies required of the board as a whole; and should establish criteria for selecting members with qualifications to be able to govern effectively.

The Ministry of Health should review the composition of the health authorities in the context of its definition of conflict of interest and take the necessary steps to ensure that conflict of interest issues are dealt with before the next set of appointments.

The Ministry of Health and the health authorities should determine the extent of orientation and training needed by board members and ensure that the needs are met.

measuring performance

Performance measurement is a key component of an effective accountability framework and essential for good management. To be of value, three aspects of performance should be measured: operational, financial and compliance. Measuring operational performance involves answering the question, is the program/service achieving the intended results in the least costly manner. Operational performance also includes developing and maintaining the capacity to deliver results in the future. Financial performance measurement assesses the achievement of financial objectives and the soundness of financial controls. Measuring compliance involves assessing both compliance with applicable legislation and regulations and the conduct of business in a fair an ethical manner.

The results obtained from measuring performance let an organization know how well it is doing in achieving its strategic direction, and provide the basis for reporting on that achievement. In the more complex relationship of the Ministry of Health and the health authorities as funded agencies, measuring performance requires that the ministry be very clear and specific about what it wants to achieve and how the authorities will contribute to those achievements. This clarity of direction then allows the appropriate performance measures to be put in place, monitored and reported.

Clearly-defined information needs and information systems that are properly aligned to capture and produce the required information are fundamental to performance measurement. Timely acquisition of relevant, reliable information is key to determining whether directions and policies are being implemented in the manner that was intended and are having the desired outcomes.

Conclusion

The ministry is aware of the importance of measuring its own performance and that of the health authorities, and is currently working with representatives of the health care industry to develop performance measures that are in line with the accountability framework adopted by the Deputy Ministers' Council and the Office of the Auditor General of British Columbia. However, the ministry first needs to articulate its vision and strategic direction in order to provide the foundation for its performance measurement system.

Once it has communicated its vision and strategic direction, the ministry in conjunction with the health authorities can then establish indicators and set targets against which performance will be measured.

In conjunction with the development of performance measures, the ministry needs to establish the appropriate information systems to ensure it is able to obtain the information it requires. The health authorities, too, should ensure that their information systems will provide them the appropriate information to meet both their governance and accountability obligations.

Ministry Expectations for Measuring Performance

The Better Teamwork, Better Care initiative has set seven health care priorities. None of these, however, has yet been translated into goals, measurable objectives or actions that would give the ministry some way of measuring its own performance and that of the health authorities.

As part of Better Teamwork, Better Care, the ministry announced it would ensure accountability of the Regional Health Boards and Community Health Councils through the use of management contracts that specify the type of services to be provided, the establishment of performance measures and standards, the approval of annual budget plans, monitoring of regular financial and performance reports, and on-site visits and audits. At the time of our review, we found the management contracts in place, performance measures and standards being developed, the budget letters in the hands of the authorities, and the authorities in the process of developing allocation plans to submit to the ministry for approval. We understand the monitoring and onsite visits are to be undertaken by the ministry in the future.

The Funding and Transfer Agreements between the Ministry of Health and the health authorities are silent on performance goals, with the exception of the specific performance contracts for tertiary-level services. For the most part, however, these contracts only specify the quantities of services to be provided, not the expected outcomes. Some of the contracts for certain services do provide general performance and monitoring expectations. For example, agreements for rehabilitation services indicate that the ministry and the service provider will work to develop measurable objectives relative to the outcomes for the programs provided. These objectives are still under development.

Although there is a focus in these agreements to develop outcomes, the priorities of Better Teamwork, Better Care are more output oriented, and it is not clear if the ministry expects the health authority to focus on the outcomes of service delivery.

Defining health outcomes is a complex task because many other factors outside the health sector affect the health of the population. Given this complexity, it is important that the development and definition of outcomes be a joint responsibility of the Ministry of Health and the health authorities. Without ministry support, the health authorities will not have the resources or infrastructure in place to support the development of outcome measures. It is the responsibility of the ministry to set out its expectations and establish standards.

The *Health Authorities Act* states that the Minister, Regional Health Boards and Community Health Councils have the authority to develop standards for the provision of health services. The Act also stipulates that the boards and councils must give due regard to the provincial standards when developing standards. Nevertheless, the responsibility still lies with the ministry to ensure that these standards are congruent and measurable. At the time of our review, standards had not yet been developed.

The health authorities we interviewed were uncertain how their performance would be measured. Some assumed it would be measured against a balanced budget and current utilization standards for acute care.

Performance Expectations for Programs Under the Ministry for Children and Families

No performance goals, service delivery standards or measures to assess the extent to which the goals and standards are being achieved are yet in place for the programs that are now delivered by the health authorities under the direction of the Ministry for Children and Families. This means that those delivering the service and those funding the service cannot evaluate performance. A memorandum to the health authorities in April 1997, signed by the ministries of Health and Children and Families, included an appendix of expectations for the services, stating: “Expectation…for these services will be jointly agreed to between the ministries and will include the following…services consistent with the goals, principles, strategic priorities and expected outcomes of both ministries.” The strategic priorities and expected outcomes referred to were not developed at the time of our review.

Identification of Information Needs

Ministry of Health

In November 1994, the then Deputy Minister of Health announced the formation of the Health Information Management Project, aimed at developing a vision for health information management, as well as a strategic planning methodology and process to move the health industry towards the vision. Its major accomplishments to date include: the development of HealthNet (a data communications network that will link all health system participants); the establishment of the Information Management Coordinating Council (which includes representatives of the health authorities, and provides a forum for discussing regional information management issues and how best to move the Province towards the vision for Health Information Management); the creation of the position of Chief Information Officer within the Ministry of Health; and the development of a draft Information Resource Management Plan.

However, in view of the changes in the structure, roles and responsibilities since the Health Information Management Project was launched, and with the project currently underway to develop performance measures, we think the ministry should reassess both the information collected and the current processes for collecting information. At this time, information continues to be collected primarily on a program-by-program basis, and continues to be focused on the outputs of the system rather than being outcome oriented. This does not address the needs of the health authorities or the ministry, under the new structure.

Health Authorities

In general, the health authorities we interviewed have not yet defined their information needs. The information currently provided to the governors is structured by service and program, and consists of financial and statistical information, as well as monthly reports on a variety of topics.

We found, however, that without having clearly defined performance expectations of the ministry and the related information needed, the governors are currently unsure that the information they are being provided is what they need to fulfil their oversight and accountability obligations. As well, some CEOs do not feel that they have all the information required for the day-to-day management of the authorities.

Exhibit 11 illustrates the key elements that should be part of any effective governance information.

The majority of the health authorities we interviewed acknowledged that current information systems will not enable management to efficiently collect performance information focused on outcomes. The systems are fragmented and do not allow for integrated data collection within regions or communities, and many areas do not have the necessary hardware or software to support their information needs. According to those we interviewed, a substantial investment in hardware and software systems will be needed before the necessary information can be collected.

Development of an Accountability Framework

When Better Teamwork, Better Care was announced, the Ministry of Health acknowledged the need for the development of performance measures and standards to meet the government's accountability requirements. To initiate and provide direction to this process, the ministry created the position of Director of Accountability and Standards and

Exhibit 11

Key Elements of Effective Governance Information

Conditions for Developing Effective Governance Information	Attributes of Effective Governance Information	Qualities of Effective Governance Information
Knowledge of business	Management direction	Explain options
Leadership	Relevance	Forward-looking
Board/management agreement	Appropriateness	Illuminates policy and administration
Appropriate reporting principles	Achievement of intended results	Recognizes appropriate time frames
Stated levels of planned achievement	Acceptance	Facilitates comparisons
Fair use of information	Secondary impacts	Promotes understanding without oversimplifying
Board capacity	Costs and productivity	
Incentives	Responsiveness	
Organizational arrangements	Financial results	
Continuity	Working environment	
Regular assessment and review	Protection of assets	
Responsibleness	Monitoring and reporting	
Validation		
Building on existing base		

Source: Based on information provided by CCAF-FCIV Inc.

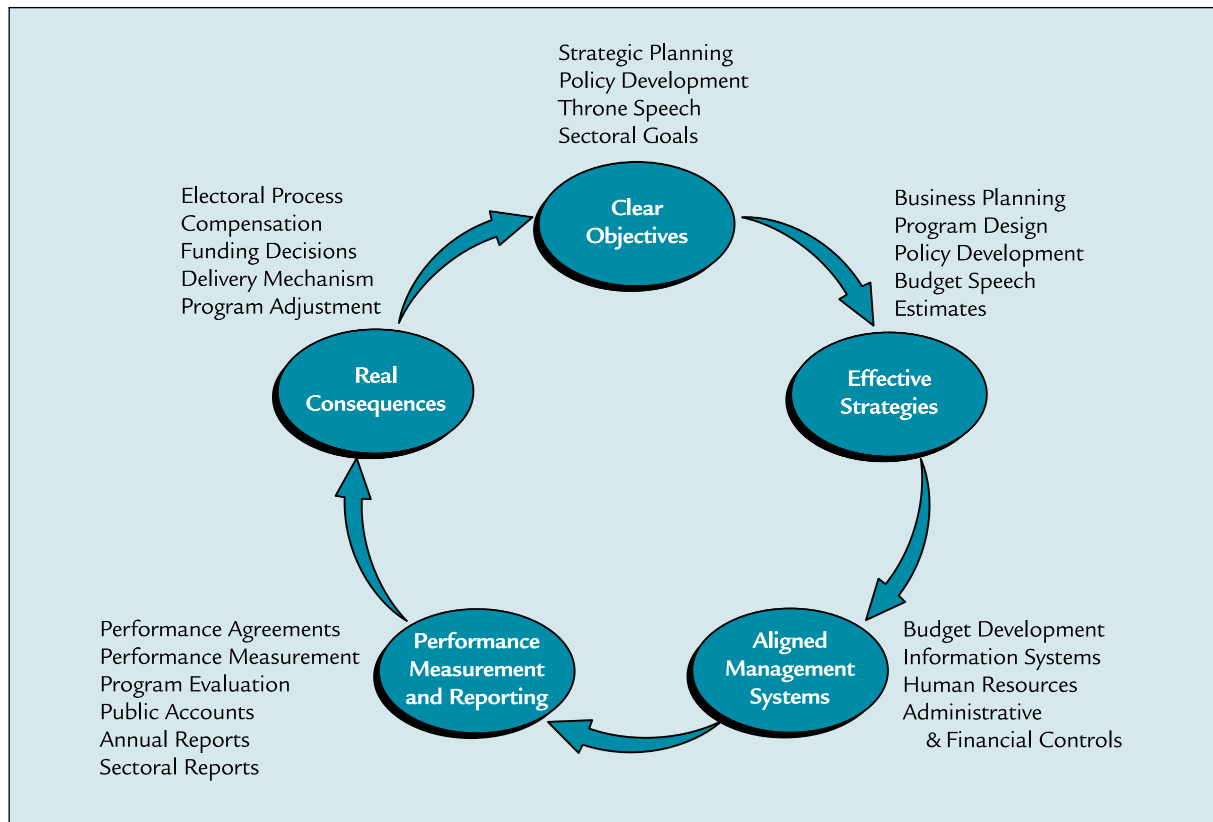
established a Joint Ministry of Health and Health Care Industry Task Force.

The mandate of the task force is "to bring representatives of the Ministry of Health and the health services industry together and develop a framework of accountability with respect to health authorities, which meets the requirements of the Auditor General, Ministry of Health and Health Care Industry. This framework is to be consistent with those developed for other Ministry of Health program areas such as Pharmacare, Medical Services Plan and British Columbia Ambulance Service."

The development of an accountability framework for the health system is in its initial stages and is based on the framework adopted by the Province's Deputy Ministers' Council in its joint report with the Auditor General of British Columbia, *Enhancing Accountability for Performance: A Framework and Implementation Plan.* Exhibit 12 shows the Performance

Exhibit 12

Public Sector Performance Management: Management Processes



Source: Auditor General of British Columbia and Deputy Ministers' Council
Enhancing Accountability for Performance: A Framework and Implementation Plan

Management System described in that document, and Appendix E sets out the Accountability Information Matrix from the same report.

We believe that by adopting the proposed framework, the ministry is heading in the right direction. However, the development of this accountability framework within the Ministry of Health and its subsequent implementation will only be successful if it is fully supported within the larger context of overall government accountability for performance, which requires a major shift in the corporate culture of government.

The Director of Accountability and Standards issued a progress report on July 2, 1997, outlining a plan for implementing an accountability framework. Subsequent to our fieldwork a draft framework was released in September 1997 which calls for it to be circulated publicly by March 1998.

Recommendations

The Ministry of Health should continue to develop its performance measurement framework and ensure that it is based on its strategic goals and objectives.

The Ministry of Health should review its current information systems and develop a plan to ensure that the information generated by it and the health authorities will enable the ministry to report on the performance of the health care system.

accountability reporting

Reporting on performance is an important component of the accountability cycle. It allows the decision-makers and those that confer authority to make informed assessments as to whether their governance mandates are being effectively carried out. It also provides the opportunity for those with the delegated responsibility to show how they have discharged their accountability requirements, the outcomes of their programs and the extent to which they have the capacity to effectively meet their obligations in the future.

Conclusion

The current reporting required by the health authorities to the Ministry of Health and by the Minister to the Legislative Assembly focuses on financial information and activities, and not on what outcomes the ministry intends to achieve nor on other important aspects of performance. The ministry needs to establish the reporting it requires from the health authorities individually and collectively, and from its own program management, so that the Minister in turn can report to the Legislative Assembly on the performance of the individual authorities as well as the performance of the health sector.

Legislative Reporting Requirements of the Health Authorities

Boards and councils are required by legislation to provide the ministry with annual budgets, a health plan, annual reports and audit reports, and to comply with the *Financial Information Act*. These requirements focus mainly on financial information; they do not include other important aspects of performance. The type and extent of performance information to be included in the report is not stated.

Exhibit 13 outlines the legislative reporting responsibilities of the health authorities. Appendix H provides information on the reporting requirements in other Canadian jurisdictions.

The CCAF-FCVI Inc. 1996 Survey of Accountability Legislation in the Health Care Sector concluded that across Canada there are unclear expectations for accountability reporting of boards and management for their performance, and the intentions of each government about strengthening performance accountability legislation are unclear. Legislation for audit of boards' accountability reporting remains concerned with financial information only. Alberta is a conditional exception, where legislation requires the audit of financial

statements, salary and benefits information, and other, yet to be prescribed, performance information.

Community Health Services Societies are required by the *Society Act* to present audited financial statements, the auditor's report, and a report of the directors to the members at an annual general meeting. The first annual general meeting must

Exhibit 13

Reporting Responsibilities of Health Authorities

Act	Applicable to*, and Section	Reporting Requirement	Performance Outcome Requirement	Financial/ Operational Requirement	Frequency of Reporting
Health Authorities Act	RHBs: 5(b) CHCs: 7(d)	Budgets	No	Yes	Not specified
	RHBs: 5(a) CHCs: 7.1(a)	Health plans	No	Describes services, programs, facilities, human resource needs and report on activities of the authority in carrying out its purpose.	Not specified.
	RHBs: 10(5) CHCs: 10(5)	Annual report	Not specified	Report on operations. Financial statements, showing assets and liabilities, income and expenditures, and statement of changes in financial position.	Required annually, no due date specified.
	RHBs: 10(4) CHCs: 10(4)	Audit report	No	Audit report relates to accounts of the board.	Required annually, no due date specified.
Financial Information Act	RHBs: CHCs: 2 and 3	Financial Information	No	Statement of assets and liabilities, operational statement, schedule of debts, schedule of guarantee and indemnity agreements, schedule of earnings above specified amount: also other information.	Within 6 months after the end of the fiscal year.
Society Act	CHSSs: 6(65)	Financial information	No	Audited financial statements, the auditor's report, and a report of the directors.	Required at annual general meeting.

*RHB — Regional Health Board; CHC- Community Health Council; CHSS—Community Health Services Societies

be held 15 months following incorporation, and thereafter at least once in every calendar year and not more than 15 months after the adjournment of the previous annual meeting.

Legislative Reporting Requirements of the Minister of Health

The *Ministry of Health Act* requires the Minister to prepare and submit to the Lieutenant Governor in Council an annual report of the work performed by the ministry. The report must be presented to the Legislative Assembly during the first session in the calendar year following the end of the fiscal year for which it was made.

Other Reporting Requirements

The Funding and Transfer Agreements of the boards and councils do not specify any reporting obligations beyond those identified in the *Health Authorities Act;* the agreements of the societies are silent on reporting requirements. The *Financial Policy Manual for Regional Health Authorities*, (draft) however, requires the audited financial statements to be forwarded to the Minister of Health by June 30 of every year.

The Ministry of Health has also prescribed for boards and councils a uniform system of financial reporting in the form of a standard chart of accounts. A chart of accounts determines the manner in which financial data is identified, aggregated and reported for planning, resource allocation, management control and results evaluation. All boards and councils must comply with the chart of accounts.

The reporting requirements of the boards and societies to the Ministry for Children and Families are still under development.

Reporting to the Public

The draft bylaws of the Regional Health Boards state that the boards will convene an annual meeting of residents of the region once in every calendar year. The agenda must include, but not be limited to:

- presentation of the audited financial statements and the auditor's report for the previous fiscal year;
- details of the current year's operating and capital expenditure plans as presented to the Minister; and
- the annual report of the board.

The *Health Authorities Act* states that the meetings of the boards and councils are open to the public; however, authorities may exclude the public from a meeting in order to protect the public interest.

The bylaws of the Community Health Services Societies state that the general public shall be invited to attend the annual general meeting. The agenda items are the same as those for the boards.

Reporting on the Performance of the Health Authorities

The Joint Ministry of Health and Health Care Industry Task Force on Accountability is developing a set of performance indicators for the ministry and health authorities to use to measure their performance. The first draft of these indicators is expected to be completed by the end of March 1998.

Recommendations

The Ministry of Health should establish the level and format of reporting it requires to be able to assess the performance of the health authorities, and should ensure that the health authorities report such information.

The Ministry of Health should structure its reporting to be congruent with the accountability framework recommended by the Deputy Ministers' Council and the Office of the Auditor General of British Columbia, and should use this information to provide a comprehensive report to the Legislative Assembly on health and health services in the Province.

ministry response

The Ministry of Health and Ministry Responsible for Seniors appreciates the opportunity to respond to the report on A Review of Governance and Accountability in the Regionalization of Health Services *issued by the Office of the Auditor General of British Columbia. As the regionalization of British Columbia's health care system is a complex and multi-faceted process involving government, health care workers, volunteers, consumers, and the public, the perspective of the Office of the Auditor General is valuable. The Ministry of Health recognizes that the success of our regionalized health care system depends upon clearly-defined lines of accountability between the Government of British Columbia, health authorities, and the public; the Ministry welcomes the guidance and support of all its partners to ensure that British Columbia's health care system continues to be among the finest in the world.*

During the first four months of the Better Teamwork, Better Care initiative—December 1996 to April 1, 1997—the Ministry of Health was focused on the legislative, administrative, legal, and financial work required to establish the governance structures—health authorities—and prepare for the transfer of authority. As the chart on page 28 of this report indicates, the Ministry of Health's priorities were focused on the appointment of members to and formation of health authorities, developing funding and transfer agreements, assisting with the amalgamation and affiliation of major health care societies with health authorities, amending the Health Authorities Act, and preparing for the transfer of staff to their new employers.

While these tasks were the major focus of the ministry's activity, preliminary work had also begun on developing the accountability mechanisms that would expand upon the Ministry of Health's expectations of health authorities. Key documents were developed and received preliminary review in their draft forms during and immediately following the time period during which the Office of the Auditor General conducted its review. Thus, it is unfortunate that at the time during which the Office of the Auditor General was focused on assessing the accountability and governance structures related to a regionalized health system, the Ministry of Health was engaged in establishing those governance structures and laying the groundwork for a fully accountable relationship between itself and those health authorities.

Since the April 1, 1997 transfer of authority from the Ministry of Health to health authorities, which also marked the end of the Office of the Auditor General's review period, the Ministry has concentrated its efforts on defining the accountability framework and its constituent parts that specify the ministry's expectations of health authority performance. Some of the steps the Ministry has taken are:

- *Developing draft performance indicators for health authorities; this document is a catalogue of performance indicators that will be used to measure and monitor the performance of health authorities in their management and delivery of the health services they govern.*
- *Establishing, publishing, and distributing Eligibility Criteria for Health Authority Membership (Ministry of Health, October 1997).*
- *Developing and consulting about Accountability System for Health Care in BC. This draft document outlines the relationships between the Ministry of Health and health authorities and catalogues the various processes and tools that currently exist and will be developed to constitute a comprehensive accountability framework for the governance, management, and delivery of health services in British Columbia.*
- *The development of the document entitled Standards for Acute and Continuing Care Programs (draft, January 1998). The final version of this document, scheduled for completion in March of 1998, will be the culmination of an extensive consultation, development, and pilot testing process leading to standards to regulate all aspects of care in institutional and community settings.*
- *The completion of the Health Services Management Policy (Ministry of Health, February 1998) that defines the ongoing conditions of the government's delegation of authority to health authorities.*
- *The Ministry has established the foundations for a long-term appointment process to govern the recruitment, nomination, and appointment members of Regional Health Boards, Community Health Councils, and Community Health Services Societies. This process is expected to be announced by April 1, 1998, will include a guide for ministry and health authorities, and will address future appointments when current interim appointments expire in December of 1998.*
- *The first seven governance policies for health authorities that will form the Health Authority Governance Policy Manual were established. These policies are requirements of the Ministry of Health and are an important component of the accountability relationship between the Ministry and health authorities. Governance policies to date concern issues such as remuneration, conduct, duties, conflict of interest, and health authority bylaws.*
- *The Ministry of Health has made an agreement with the Health Association of British Columbia that will see it assume responsibility for education and training of health authority members.*
- *The next major step will be delineating the ministry's expectations of health authorities with respect to health planning activities and developing comprehensive instructions for health authorities to develop health plans using the accountability tools that have been prepared for their use.*

The Ministry of Health believes that its work to date has been consistent with the recommendations of the Office of the Auditor General's review of regionalization and, as it continues to further develop and refine the accountability system, will attend closely to both the spirit and the content of them.

appendices

appendix a

New Directions for a Healthy British Columbia

This document was issued in 1992 and provided the following direction for British Columbia's health system:

Vision:

Healthy citizens and healthy communities in British Columbia.

Mission:

To promote and provide for the physical, mental, and social well-being of all British Columbians.

New Direction #1 Better Health

Priority Actions:

- set up a Provincial Health Council;
- establish a clear set of health goals;
- strengthen the advocacy and advisory role of the Provincial Health Officer;
- provide greater attention to health promotion and prevention of injury and illness;
- develop health policy frameworks for specific groups (aboriginal people, multicultural populations, youth, etc.); and
- make health impact assessment part of the approval process for new government policy, programs, and legislation.

New Direction # 2 Greater Public Participation and Responsibility

Priority Actions:

- extend the Ombudsman's authority to hospitals, boards of hospitals, and governing professional bodies;
- amend legislation to ensure that lay representatives constitute at least one-third of all professional governance bodies;
- enable clients to have access to their own medical records;
- establish a health information network;
- distribute information on average and specific care costs;
- develop information strategies, targeted at specific health issues, regarding the appropriate use of health services; and
- implement the ***Freedom of Information and Protection of Privacy Act.***

New Direction #3 — Bringing Health Closer to Home

Priority Actions:

- assist in the development of local structures of governance including Community Health Councils and Regional Health Boards, prepare enabling legislation, and identify "fast start" communities and regions;
- encourage and support community health centers and comprehensive health organizations;
- continue to promote and develop a continuum of service;
- establish a rural health strategy; and
- restructure the Ministry of Health; devolve responsibility for the direct delivery of services to regional and community boards; reorganize and refocus the ministry to better address regional and community needs; and provide opportunities for training and skill development to enable staff to fulfill the changing role.

New Direction #4 — Respecting the Care Provider

Priority Actions:

- place management of the labor adjustment process in the hands of organizations most directly affected by the change;
- pursue a policy of pay equity, within available funding;
- establish policies, monitoring systems, and prevention strategies to address abuse of providers in the workplace and ensure a safe working environment; and
- strengthen support for care providers, using initiatives such as expanding the scope of respite options for informal care providers.

New Direction #5 — Effective Management of the New Health System

Priority Actions:

- increase emphasis on accountability, for example, the Provincial Health Council will publish an annual report on health and health issues in the Province that will include a "report card" on the health of British Columbians; and professional organizations will also be expected to strengthen their accountability to the public;
- expand the mandate of the Health Professions Council to include the evaluation of scopes of practice and title protection of currently licensed professions;
- undertake management and financial audits within the ministry to identify potential savings in the short term;
- develop a formula for the initial funding of regional boards and community councils;

- develop and promote, in collaboration with regional boards and community councils and physicians, alternative payment mechanisms for physicians;
- achieve a provincial acute care target ratio of 2.75 beds per 1,000 population by 1996;
- develop new standards and protocols for collecting information and for providing access to the information system;
- establish standards and models for evaluating outcomes;
- make evaluation and utilization management mechanisms mandatory for all agencies receiving government funding;
- prepare a comprehensive human resource plan for the new health system;
- implement a British Columbia physician resource management plan to complement the national plan; and
- create in keeping with the recommendations of the Korbin Commission, a single organization to coordinate human resource management and labor relations issues in the health system.

appendix b

Regionalization Assessment Team Recommendations

The Regionalization Assessment Team, in its November 1996 report to the Minister of Health and Minister Responsible for Seniors, recommended that:

1. Responsibility for the health care system not be the same in all regions of the province.
2. Different governance approaches be implemented in rural and urban areas.
3. 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.
4. 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.
5. 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.
6. 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.
7. There be no elections to Regional Health Boards (RHBs) and Community Health Councils (CHCs).
8. There be no remuneration for individuals who sit on RHBs or CHCs.
9. 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.

10. 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 neighboring CHCs or integrated into an adjacent region. Any decisions to change boundaries should be informed by analysis of the relevant patient referral patterns.
11. More emphasis be put on developing and articulating clear strategies for reducing unnecessary health expenditures.
12. The Minister consider providing physicians and unionized health care providers a vote on the governing bodies of the regional health care authorities.
13. 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.
14. The Hospital Group Boards in Vancouver remain intact.
15. The Minister introduce the legislation to enable amalgamations requested by a local board or council.
16. The Minister consider extending affiliation arrangements to smaller facilities and community services operated by societies with unique mandates.
17. 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.
18. The Minister set standards for health care delivery and establish a mechanism to audit and report on the performance of providers.
19. The Ministry of Health be redesigned to reflect a health care leadership role rather than a service delivery role in a new regionalized system.
20. 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.

appendix c

CCAF Characteristics of Effective Governance

(Source: CCAF-FCVI Inc., an Ottawa based Canadian Research and Educational Foundation)

1. **Governing bodies are comprised of people with the necessary knowledge, ability, and commitment to fulfill their responsibilities.**

   The focus is on the capacity of the group of directors collectively to have the characteristics necessary to allow them to meet their obligations. This principle contemplates that directors will see their obligations as extending beyond merely putting in the time required to having a real desire to set the course for the organization.

2. **Governing bodies understand their purposes and whose interests they represent.**

   The difference between managing and governing must be understood. This means that the boundary between senior management responsibilities and board responsibilities must be well established. One group steers, the other rows. The independence from management must be understood. Governing bodies must also understand whose interests they serve. This requires understanding and balancing government priorities and corporate priorities.

3. **Governing bodies understand the objectives and strategies of the organization they govern.**

   Board members should be well versed in the basic objectives of the corporation and approve the strategies to be used to achieve those objectives.

4. **Governing bodies understand what constitutes reasonable information for good governance and obtain it.**

   Information governing bodies need can have different attributes depending on the uses the information is to be put to. Quality, quantity and timeliness must be considered. The information may be backward-looking, highlighting expenditures made or performance levels achieved. It may be forward-looking, identifying performance measures and intended performance targets. The information may be provided by internal or external sources, which in turn may affect the level of assurance governing bodies have

about the completeness and reliability of the information. The characteristics and attributes of information needs have sufficient scope that governing bodies need to identify to management the different information needs they have and ensure that systems are developed to provide that information flow.

5. **Once informed, governing bodies are prepared to act to ensure that the organization's objectives are met and that performance is satisfactory.**

   Having the right people, understanding the strategies and objectives and getting information needs met does not necessarily lead to good governance. When presented with evidence of the need to act, governing bodies must have the courage and integrity to act on the information. Marginal decisions are not the issue here, but the willingness to act on the decisive matters facing the governing body. Governing bodies must have the capacity to act on the information given to them. Responsibility must be balanced by the authority and power needed to act.

6. **Governing bodies fulfill their accountability obligations to those whose interests they represent by reporting on their organization's effectiveness.**

   Someone gives authority for the governing body to act. An obligation exists for the governing body to account for its actions. The accountability relationship inherent in this principle is the expectation that the governing body may be accountable to more than one group and different levels of accountability may exist. Within Crown corporations, the shared decision-making may cloud some of the accountability relationships. These must be clearly understood if accountability is to be exercised by those with the authority to act.

appendix d

Overview of the Accountability System for Health Care in British Columbia

(Source: Ministry of Health)

Federal Role

The *Constitution Act* (1867) gives the federal and provincial/territorial governments the legislative authority to make laws regarding health services for Canadians. The derivative laws that are enacted by federal and provincial governments allow delegation of authority and responsibility for delivery of health services.

The federal role in health is primarily to encourage and financially assist the development of comparable public health services nationally.

The federal government applies the *Canada Health Act* to medically necessary services, and uses its block spending powers to set up and maintain national programs or initiatives (e.g., Medicare) and standards (e.g., those related to public administration, comprehensiveness, universality, portability and accessibility). In addition, the federal government directly administers, through Health Canada, statutes that regulate products used in health care (e.g., *Food and Drug Act*) or that maintain protection of health nationally (e.g., *Hazardous Products Act*). The federal government is also responsible for the direct provision of select health services on federal lands (e.g., national parks) and for specific groups (e.g., "registered Indians").

Provincial Role

The provincial/territorial powers, rights, privileges and authorities for health care are also vested through the *Constitution Act* (1867). The provinces and territorial governments are the first-line authorities for developing laws related to health services and establishing programs within their jurisdictions, as long as these efforts do not contravene federal regulatory frameworks.

In British Columbia, the principle of parliamentary democracy requires that the political leadership of the Province (the Premier and Cabinet) retain the confidence of the Legislative Assembly, whose members, in turn are accountable to their constituents through election. The

Cabinet and Cabinet Caucus are responsible for setting the overall direction for the government of British Columbia, including the strategic direction for the health system.

The Role of the Public and the Legislative Assembly

The provincial Legislative Assembly and its Members receive their ongoing authority from democratic election by the people of British Columbia.

Aside from the electoral process, Members of the Opposition in the Legislative Assembly question, and receive reports and documents from, the government and its Ministers about the legislative framework, public expectations for health care, financial resources for health care, and any other matter regarding stewardship and government performance.

The public's right to know the provincial government's performance record on matters pertaining to the health system provides the highest level of accountability for the health system.

Minister of Health's Role

The *Ministry of Health Act* (1979) assigns duties, powers and functions to the Minister of Health, including responsibility for "all matters relating to health" that are assigned to the Minster under any Act or order by the Lieutenant Governor in Council and that are not, by law or order, assigned to another branch or agent of government. Consequently, the Minister of Health is responsible in law for the overall health care system of British Columbia, and is accountable for reporting to the legislature on the province's health care system, including the performance of services and facilities funded by the health care budget.

Ministry of Health's Role

The *Ministry of Health Act* also creates the Ministry of Health, which the Minister presides over and who in turn is responsible to the Lieutenant Governor in Council for the direction of the ministry. Under the direction of the Minister, the Ministry of Health is in charge of all matters relating to public health and government-operated health insurance programs. The Minister must submit a report to the Lieutenant Governor in Council on the work performed annually by the ministry. The Ministry of Health acts as agent of the Minister of Health in carrying out the office's responsibilities, and supports the Minister in his or her duties.

The Role of Health Authorities

The health authorities in British Columbia consist of:

- Regional Health Boards,
- Community Health Councils, and
- Community Health Services Societies.

The health authorities are defined in Ministry of Health legislation, and are created and defined through the *Health Authorities Act,* its regulations and recent amendments (May, 1997), and the *Society Act* and its resulting bylaws. The Minister designates through regulation the specific geographic and service population boundaries of each health authority.

The purpose served by health authorities varies depending on whether they are regional, community or service-based.

appendix e

Accountability Information Matrix

Accountability Information Matrix: Ministry/Crown Corporation Level		
What questions should accountability information answer?	What information is needed to allow these questions to be answered?	
	Planning	Results
Operational:		
Is the organization achieving what it set out to achieve?		
What is the purpose of the organization?	• legal mandate • mission	
What are the challenges facing the organization?	• analysis of key issues and trends	
What are its overall long–term goals, and how well is it progressing toward them?	• measurable (outcome focused) targets for long–term goals	• key outcomes/performance measures on long–term goals
Are its programs achieving what they are meant to achieve in a cost–effective way?		
Are its programs:		
– needed (that is, relevant)?	• client profile • program objectives • link to organization and government–wide objectives	• results of evaluations carried out
– achieving what was intended (that is, effective)?	• intended outcomes • schedule of evaluations to be carried out • planned service delivery standards • intended levels of user acceptance	• outcome measures • results of evaluations carried out including details about secondary impacts • actual service delivery standards • actual levels of user acceptance
– achieving at a reasonable cost (that is, efficient and economical)?	• planned full cost of programs • planned unit cost of outputs • planned quantity/quality of output	• actual full cost of programs • unit cost per output • actual quantity/quality of output
Is the organization maintaining the capacity to deliver results in the future?		
Does the organization have the ability to maintain or improve results, and the capacity to deal with the future?	• details of any specific initiatives, designed to improve organizational capacity	• assessment of financial condition, protection of assets, employee skills, work environment, and operating controls

Accountability Information Matrix: Ministry/Crown Corporation Level		
What questions should accountability information answer?	What information is needed to allow these questions to be answered?	
	Planning	Results
Financial:		
Is the organization achieving its financial objectives?		
What are its financial objectives, and are they being realized?	• planned operating revenues and expenditures • planned capital expenditures • planned financial position, including debt	• actual revenues and expenditures • actual capital expenditures • actual financial position, including debt
Are affairs managed according to sound financial controls?	• details of any major changes to be made to financial controls	• management statement of the adequacy of controls
Compliance:		
Are the organization's affairs conducted in accordance with legislated requirements, and with expected standards of conduct?		
Is spending kept within the limits approved by the Legislative Assembly?	• voted appropriations	• statements of actual expenditures compared to voted appropriations
What laws does the organization need to comply with for (a) the conduct of business and (b) the operation of specific programs, and is it complying with them?	• identification of relevant laws	• management statement of compliance
What are its standards of conduct, and is it complying with them?	• identification of standards of conduct	• management statement of compliance
What are government's internal social policy objectives, and how well is the organization achieving them?	• long–term goals • annual objectives	• progress towards long–term goals • annual achievement
Are there adequate controls designed to ensure compliance with legislation and standards of conduct?	• details of any major initiatives to improve control over compliance	• management statement of adequacy of compliance controls

Source: Auditor General of British Columbia and Deputy Ministers' Council
Enhancing Accountability for Performance: A Framework and Implementation Plan

appendix f

Summary Findings of the CCAF-FCVI Inc. Survey of Accountability Legislation in the Health Sector

In 1996, CCAF-FCVI Inc. carried out a survey of accountability legislation in the health sector in Canada, focussing on boards. It reported on the survey results in March 1997. The general pattern, with some exceptions, was as follows:

- The legislation is silent on performance expectations for management and on management's reporting to the board.
- There are varying degrees of performance expectations for boards, which are still sorting out the balance of their powers, duties and accountabilities.
- There is very little in the way of expectations for performance reporting by boards, beyond the usual financial statements.
- Legislation is concentrating on structural transition and setting up regional boards to carry out executive government health care policy.
- There are no expectations for Ministers' accountability reporting.
- Provisions have been made for the attestation audit of financial statements only.

appendix g

Summary of the Numbers and Composition of Regional/District Health Boards Across Canada

Province	Supreme Agency	Number of Boards	Boards Oversee Hospitals	Basis of Membership of Regional/District Boards
BC	no	52[1]	yes	Appointed by the Minister.
Alberta	no	17	yes	By 1999, one-third to be appointed by the Minister, two-thirds elected.
Sask.	no	30	yes	One-third appointed by the Minister, two-thirds elected.
Manitoba	no	11[2]	yes[3]	Minister appoints authorities' boards; hospital boards are per each hospital's Act.
Ontario	no[4]	33	no[3]	District Health Council members are appointed by Lieutenant Governor in Council or Minister, hospital boards per their Acts.
Quebec	no	17	yes[5]	Most elected; some appointed by designated regional stakeholders.
New Brunswick	no	8	yes	Minister appoints four of the 10-14 members of each board; rest as per regulations or the hospital corporations' bylaws.
Nova Scotia	no	4	yes	To be one-third appointed by the Minister, two-thirds by local community boards.
Prince Edward Island	yes	5	yes	Minister appoints the agency's members; regional boards to be elected, but yet to be worked out.
Nfld.	no	8 hospitals and 4 health	yes	Appointed by the Minister, but provision exists for election.

[1] Eleven Regional Health Boards for metropolitan areas, 34 Community Health Councils for smaller population areas. There are also 7 Community Health Services Societies, composed of Community health Council members in areas where there are no Regional Health Boards. The purpose of the societies is to provide specified services that cross council boundaries as planned.

[2] Manitoba will have new legislation in 1997 for 10 rural boards and 1 urban board.

[3] Hospitals retain their own boards; those retained in Manitoba after 1997 will have limited responsibility.

[4] The Ontario executive government's province-wide Health Services Restructuring Commission appointed in 1996 has a four-year mandate with power to close hospitals.

[5] The Regional Health Boards oversee most of these establishments.

Source: CCAF-FCVI Inc. Survey of Accountability Legislation in the Health Sector (1997)

appendix h

Reporting Requirements in Other Canadian Jurisdictions

Alberta

The Health Authority

- The *Government Accountability Act* states that: "the governing body of an accountable organization (a regional health authority, subsidiary health corporation, community health council or provincial health board under the *Regional Health Authorities Act*) must prepare and give to the Minister responsible for the accountable organization a business plan and annual report for each fiscal year containing the information, in the form and at the time acceptable to the Minister."
- The *Regional Health Authorities Act* states that: "within the time prescribed in the regulations, a regional health authority shall provide to the Minister an annual report on its activities for the previous fiscal year, and the report must

  (a) be in a form acceptable to the Minister,

  (b) contain audited information respecting the regional health authority and its subsidiary health corporations including

    (i) financial statements,

    (ii) information on the remuneration and benefits paid to members, officers and senior employees as specified in the regulations, and

    (iii) other performance information specified by the regulations, and

(c) contain any other information required by the regulations."

"A meeting of a regional health authority or community health council must be open to the public unless the regional health authority or community health council, based on considerations set out in the regulations, determines that holding the meeting or part of it in public could result in the release of

(a) information that might impair the ability of the regional authority or community health council to carry out its responsibilities, or

(b) information relating to the personal interest, reputation or privacy of any person."

The Minister

"The Minister shall present copies of the annual report received by the Minister for each regional health authority before the Legislative Assembly if it is sitting, and if it is not, within 15 days after the commencement of the next ensuing sitting."

Nova Scotia (from the CCAF- FCVI Inc. survey)

- Regional boards submit annual reports to the Minister containing such information as the Minister requires, and provide whatever other information the Minister or department asks for. The only legislatively prescribed performance information for the minister is the audited financial statements, although the Hospital Reference Manual requires other reports. There is no requirement for boards to report to the public.

Prince Edward Island

The legislation in Prince Edward Island created, along with a regional health authority, a Crown corporation called the Prince Edward Island Health and Community Services Agency. The agency provides for, and oversees, the delivery of health and community services.

- *The Health and Community Services Act* states:

  "A regional authority shall submit to the Agency

  (a) an annual report; and

  (b) such other information as the Agency may reasonably require about the operation of the regional authority and the delivery of health and community services in the area in which the regional authority has jurisdiction. A regional authority shall hold an annual general meeting at which information about the operation of the regional authority and the provision of health and community services is presented."

  "The Agency shall submit to the Minister

  (a) an annual report; and

  (b) such other information as the Minister may reasonably require about the operation of the Agency and the delivery of health and community services in the province."

Saskatchewan

- The *Health Districts Act* states:

Reports

"35(1) A district health board shall submit to the minister, in a form specified by the minister, any reports that the minister may request from time to time."

"(2) Without restricting the generality of subsection (1), a district health board shall, within three months after the end of the fiscal year or at any other time approved by the minister, submit to the minister, with respect to the fiscal year:

(a) a report of the district health board's services and activities and their costs;

(b) a detailed audited set of financial statements;

(c) a detailed audited schedule of investments; and

(d) a report on the health status of the residents of the health district and the effectiveness of the district health board's programs."

Meetings

"37(1) At least twice in each fiscal year, a district health board shall conduct a meeting of the district health board to which the general public is permitted access.

(2) At one of the meetings in subsection (1) the district health board shall present:

(a) an operation and expenditure plan for the next fiscal year; and

(b) a report on the health status of the residents of the health district and the effectiveness of the district health board's programs."

appendix i

1997/98 Reports Issued to Date

Report 1

Performance Audit

Earthquake Preparedness

Earthquake Preparedness: Summary

Report 2

Report on the 1996/97 Public Accounts

Report 3

A Review of Governance and Accountability in the Regionalization of Health Services

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