Report to

Ministry of Health Services

Regional Hospital District Cost Sharing Review

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1. EXECUTIVE SUMMARY

Sierra Systems was engaged by the Ministry of Health Services to conduct a review of the cost sharing processes between the Ministry of Health Services, Health Authorities, and the Regional Hospital Districts (RHDs). The review considered the following questions:

1. What is the appropriate role for RHDs in capital planning and contribution decisions? What is required to implement the appropriate role?
2. What are the capital process concerns of the RHDs, Health Authorities, and the Ministry? What is required to simplify the processes and address the concerns?

The proposed model is the culmination of an iterative process that involved two phases of stakeholder consultation. The result is a workable solution that effectively addressed the issues and concerns of key stakeholders.

Sierra Systems worked closely with the Steering Committee established to oversee this project. Extensive stakeholder consultation produced an exhaustive catalogue of issues of concern to stakeholders that were categorized into the following four themes:

- Issues related to accountability;
- Issues related to the definition of capital for the purposes of RHD cost sharing;
- Process issues; and
- Unique structural issues.

Guiding principles were then established as a framework for the development of potential solutions. These principles included taxation and accountability; consistency with modern health services; capital demands that are consistent with local financial capacity and ensuring that contributions benefit the local community.

1.1. Overview of Recommendations

Recommendations are organized on the basis of the priority alignment of the Guiding Principles that were developed for this report. Key among these were issues of accountability and taxation that flow directly from the foundation of democratic government. It was clear throughout the process that RHDs were fundamentally concerned about their role as funders in a process that many found less than fully accessible. Recommendations related to process are primarily aimed at meeting this fundamental objective.

Accountability

A core recommendation focuses on the principle that decisions by RHDs to make capital contributions are made on the basis of their understanding of local requirements and capacity.

The effect of this recommendation is to move the process in a direction that recognizes the democratic foundation behind the RHDs.

Recommendation 1: *"RHD contributions are voluntary. The onus must rest with the Health Authority to develop and maintain effective working relationships with the RHDs in its region."*

In turn, Health Authorities have been given significant and complex mandates to deliver health services across extensive geographies and large and diverse populations. These complex mandates relate to the creation of high quality health outcomes, for which the Ministry holds Health Authorities accountable. Effectively, we have a dual accountability circumstance in which RHDs are accountable to their local taxpayers while the Health Authorities are accountable for health outcomes to the Minister and the Government of BC.

Recommendation 2: *"Health Authorities must be unfettered by cost-sharing requirements in their ability to provide required health services regardless of the fiscal capacity of a region."*

The effect of Recommendation 2, in combination with Recommendation 1, is to recognize the removal of the traditional role of the Ministry in the capital process. This recommendation also recognizes the intent of the new BC health delivery structure.

The outcome of the review, including the extensive discussions carried on across BC leads us to the conclusion that the general principle of a maximum 40% capital contribution by RHDs is sound and should continue. At the same time, there has to be recognition of variation in the ability of RHDs to contribute to capital projects. There will clearly be cases where a Health Authority must make capital investments to deliver health outcomes without being able to obtain an RHD contribution.

Recommendation 3: *"RHDs should not be expected to contribute more than 40% of new projects.*

In practical terms, projects requiring the investment of capital, that are eligible for RHD capital contributions, will be funded by a combination of Health Authority, Foundation and RHD contributions. Our recommended approach requires that the outcome must be a result of sound information exchanges, discussion and open decisions by the RHDs. Recommendation 4 focuses on the key role of the Health Authorities in setting capital budgets, maintaining the capital stock and adding capacity as needed to meet their mandates.

Recommendation 4: *"The Health Authority must develop budgets and plans to construct, acquire and maintain capital assets."*

The capital planning role of the Health Authorities logically leads to a consideration of what happens in the event of a cost overrun on a particular project. Traditionally, there has been an expectation that management of such issues would be joint between the local health organization and the RHDs. In the new context, the principle has to assume that Health

Authorities take responsibility for cost overruns while maintaining the capacity to seek RHD support as needed.

Recommendation 5: "*Budgetary overruns or delays should become the responsibility of the Health Authority. RHDs may still choose to help fund overruns*."

These recommendations provide balance between the capacity and interests of RHDs and the mandates and responsibilities of the Health Authorities. They are structured to provide the best possible opportunity for the development of real partnerships at the local level while meeting fundamental principles.

Definition of Capital

The report provides for a significantly expanded definition of capital eligible for funding contributions by the RHDs. The gist of the recommendations is to create two basic categories of capital projects, with minor projects involving items that fall below $100,000. A second category involves larger projects.

Recommendation 6: *"For the purposes of RHD cost sharing, the categories of capital should be simplified:*

- *Projects or single pieces of equipment with a value of less than $100,000*
- *Projects or equipment with a value greater than $100,000*
- *The classification of equipment value must take into account the overall value of a 'system' of which a single piece of equipment is a part.*
- *P3's require the development of clear accounting definitions to recognize ownership."*

This recommendation also addresses the question of how P3 projects are to be treated; cautioning the Ministry to ensure accounting approaches and definitions maintain a link between RHD capital contributions and principles of public title related to their contributions.

With respect to minor capital items, the report urges RHDs to provide for lump sum funding with an appropriate level of disclosure and reporting associated with them. This ensures that Health Authorities can budget with some confidence for minor items and that RHD accountability is maintained. The effect of this recommendation is to make a procedure already used by most RHDs universal. The allocation of a lump-sum provides some certainty to the Health Authorities with respect to their budgets. At the same time, sound reporting principles would ensure that RHDs have full knowledge of what their contribution was actually used for.

Recommendation 7: "*RHDs should allocate lump-sum contributions to minor items below $100,000.*"

The proposed definition of capital effectively expands the range of projects that could be eligible for capital contributions. In turn, Recommendation 8 underlines the fact that it is not intended to increase the proportion of health capital projects that is funded by RHDs or require RHDs to assume new debt beyond historical and projected funding levels for traditional hospital capital projects. At the same time, it needs to be recognized that the total value of RHD contributions

may rise or fall in response to the decisions of RHDs and out of the processes of discussion between them and the Health Authorities.

Significant debate during the consultations focused on the possibility that an expansion of the types of projects eligible for cost-sharing might put upward pressure on RHD contributions. This is not the intent of the Minister, nor will that be an outcome of these recommendations. RHDs will decide independently and on the basis of the facts presented by Health Authorities what the value of their contributions will be. It is also not expected that a set ratio of contributions will be maintained.

Rather, it is expected that the overall value of contributions will remain the same, while the percentage contributions for particular projects will vary between 0 and 40 percent, depending on decisions made by the parties involved.

Recommendation 8: "*A change in the definition of capital should not increase the overall ratio of financial contribution of the RHDs or require RHDs to assume new debt beyond historical and projected funding levels for traditional hospital capital projects.*"

Procedure

This report recommends the establishment of procedures for consultation and communication that are designed to promote open discussion of capital requirements, responsiveness to local requirements and capacity by the Health Authorities, all organized against a background of long-term planning and discussion. We recommend strongly that the new processes be launched in the Fall of 2003. It is generally understood that these processes will require some time to implement and to become meaningful to people.

Recommendation 9: "*Implementation of the recommendations process should begin in the fall of 2003 with a joint planning meeting between each Health Authority and its RHDs.*"

The key to the new process is a joint planning meeting to be held in the Fall of each year. At this meeting the Health Authority would present its rolling 5-year capital plan along with background information and the basis for its planning decisions. Increasingly, these joint planning events should become sessions in which the Health Authorities and RHDs exchange ideas and views and tune the capital plans presented by the Health Authority. Key to creating an effective process is the movement of Health Authorities to a rolling 5-year capital plan. Once again, we assume that it may take some time to become effective in building these plans, but the direction should be absolutely clear.

Recommendation 10: "*Health Authorities should move towards a 5-year rolling capital plan and a standard communication process.*"

Recommendation 11: "*In the fall, before Health Authority and RHD budgets are finalized a joint planning meeting (or series of meetings) should be held to discuss the content of the Health Authority's five-year capital plan.*"

Recommendation 12: "*The joint planning meeting should be used to meet education objectives by providing an opportunity for the Health Authority to explain its planning assumptions as well as the specific health outcomes that it is pursuing."*

The process further contemplates the addition of a mid-cycle 'reality check' meeting between each Health Authority and its RHDs. The purpose of this meeting will be to discuss any changes required in the overall plan and to assess the viability of the original plan. The timing of this meeting will be set to meet budget-setting requirements of RHDs.

Recommendation 13: "*The mid-cycle meeting reviews the five-year capital plans and discusses any necessary amendments."*

The outcome of the contemplated process is to eliminate coordination issues that existed in the past and to ensure a flow of information and serious discussion of the capital funding concerns of the health system generally. Recommendation 14 specifically refers to the creation of a 'cyclical' process to ensure that RHDs and Health Authorities meet on a regular basis and discuss critical issues.

Recommendation 14: *"A regular cyclical process is recommended to eliminate coordination issues."*

Structure

The report specifically addresses changes in legislation that will be required to bring reality to this new model. Such changes include the elimination of specific references to 'hospitals and hospital facilities'. In addition, references in legislation that provide for specific rules that the Ministry must follow with respect to capital funding issues (60%) are no longer consistent with the new health delivery model since the decisions regarding priorities are made by Health Authorities. A project focused on re-drafting legislation will be required.

Recommendation 15: *"Specific reference to 'hospitals and hospital facilities' should be replaced with a broader definition of what is eligible for cost sharing."*

The process and structural recommendations are designed to yield a system that assigns appropriate responsibilities to RHDs and Health Authorities. They seek to draw a very clear distinction between the roles of Health Authorities and RHDs, ensuring that each fully appreciates its pivotal role in advancing the delivery of health services. One of the key challenges as the new process is implemented will be to ensure that both sets of organizations learn to develop effective partnership relations.

1.2. Implementation

Although it would be unreasonable to claim that a consensus now exists, it is reasonable to assume that stakeholders that have participated in the development of the model are inclined to give it an opportunity to succeed.

It may take several years for the new process to reach its full potential. In particular, it should be noted that at the beginning of the cycle of planning events in the Fall of 2003, Health Authority plans should be expected to be quite firm and relatively difficult to alter. New processes and new relationships will take some time to develop, and it should be expected that the pace of adjustment and relationship building would vary across the province.

The proposed model, once implemented will provide:

- Standardized process with local variation
- Clearly defined roles and responsibilities
- Improved coordination of planning and budgeting activities
- Greater certainty and forecasting ability
- Improved flexibility

2. BACKGROUND

Capital costs associated with the construction, acquisition and maintenance of hospital facilities and many types of equipment are shared between the Health Authorities and RHDs according to criteria established in legislation. The Province's role is to review and provide sign-off for significant or larger projects.

Major changes in the structure of the BC health system have altered historical relationships and have left in place processes that are not fully synchronized with the new reality. A number of issues have been raised concerning the efficacy and equity of the current planning relationship. These issues have created pressure for a comprehensive review of the capital cost sharing process. The willingness of RHDs to contribute to health capital is not one of the drivers for this project, but the processes surrounding capital cost sharing have been identified as a significant problem.

This project focuses on two primary objectives. The first is to identify the appropriate role for RHDs in capital planning and contribution decisions and to develop an implementation strategy for this proposed new model. The second objective is to identify capital process concerns of RHDs, Health Authorities and the Ministry that will be addressed through process modifications and associated policies, regulations and legislation. Any new model would include enhanced administrative processes for planning and approving cost-shared projects. Improved clarity will enhance the quality of communications, help resolve conflicting priorities and support efficient decision-making in the provision of health facilities across the province.

Strategic investment planning is the responsibility of the Health Authorities. The Province currently provides funding that is nominally equivalent to a proportion not exceeding 60% of the cost of capital projects, including construction projects and some equipment purchases for hospitals as defined in the *Hospital Act.* In practical terms the new health delivery model in BC transfers resources to Health Authorities that include capital and operational requirements. It is worth noting that the Ministry's contribution in the new model is not directly traceable to particular projects. Rather, Health Authorities are provided with budgets that include capital funding. Hence, we have used the word 'nominal' to describe the Ministry contribution.

The remaining required capital funding is drawn from other sources such as the RHDs and foundations. In the case of the two Health Authorities with major populations not covered by RHDs, nominal provincial capital funding necessarily amounts to as much as (depending on foundation funding available) 100% of projects in areas not covered by RHDs.

RHDs have the authority to borrow the funds and generate revenue for repayments from the local property tax base. However, some RHDs prefer to operate on a cash basis or to generate reserve funds in anticipation of large capital projects.

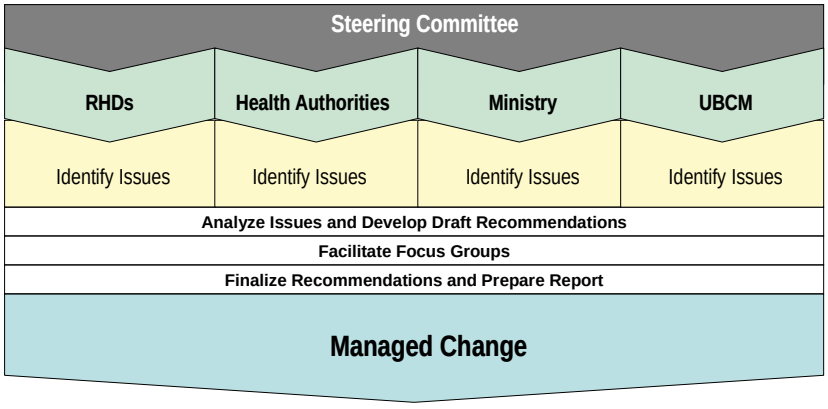
The health system in British Columbia has undergone several significant restructuring processes in the past ten to fifteen years. The recent consolidation of regional Health Authorities has had a significant impact on the relationship between the Province and the RHDs. Many RHDs feel that

communication at both the board level and the staff level has deteriorated, resulting in increased pressure to re-evaluate the relationship between the Province, Health Authorities and the RHDs.

Recent changes to the provincial capital budget process have also had an impact on the capital cost sharing process between Health Authorities and RHDs. In the past, many RHDs depended on the Ministry to analyze and prioritize the capital plans submitted by the regional health organizations. If proposed plans received the approval of the Ministry, RHDs had sufficient confidence to give their support as well. Now that the Ministry no longer performs this function, some RHDs are less certain of their ability to evaluate proposals effectively.

2.1. Methodology

This project was undertaken with the direction of a Steering Committee comprised of representatives of the Ministry of Health Services, Health Authorities, RHDs and the Union of BC Municipalities Health Committee. Sierra Systems used an iterative approach to give participants the opportunity to provide input into all stages of the project and the final recommendations. This participatory process maximized the collective knowledge of stakeholders and began the process of moving toward the final outcome.



The first phase of consultation involved soliciting broad input from RHDs and Health Authorities using a standard survey tool as a framework for discussion. The purpose of this phase of consultation was to gain a comprehensive understanding of all relevant issues from a variety of perspectives. Some RHDs took part in one-on-one telephone interviews, while others requested telephone conference calls or prepared written submissions and discussion papers. By the end of the first phase of consultation every RHD had provided input in some form. Sierra Systems also conducted interviews with the Chief Financial Officers and/or the Capital Planners of each of the five Health Authorities, and telephone interviews with several Chief Executive Officers. Representatives of the Ministry of Health Services and the UBCM Health Committee were also engaged during this phase of consultation.

Issues identified during this first phase of consultation were organized into several broad themes and catalogued. This document was distributed to stakeholders prior to the second phase of consultation and was amended to reflect new information gathered during the second phase of consultations. The complete Issues Summary is presented in Appendix B.

Some fundamental principles and strategic objectives were then identified to guide the development of potential options. These were used as a reference against which potential recommendations were evaluated and tested. Any option element that was not consistent with the principles and objectives was eliminated.

The set of draft recommendations was then presented to stakeholders for discussion in a series of seven regional focus groups. Half-day meetings were held in the following locations:

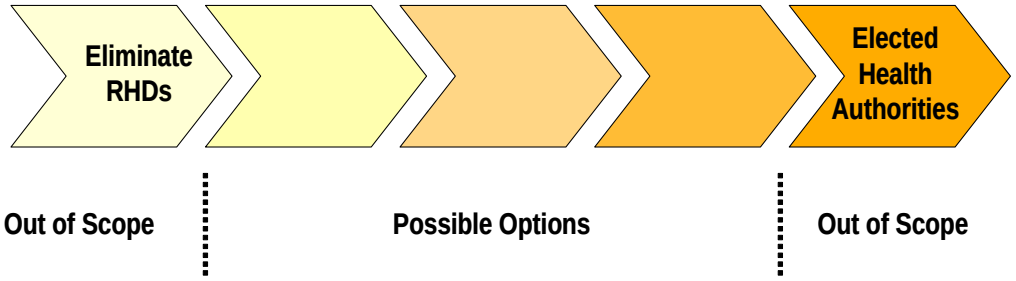
- Nanaimo
- Chilliwack
- Kelowna
- Vancouver
- Prince George
- Dawson Creek
- Terrace

Participants included representatives from RHDs, Health Authorities, the UBCM Health Committee and the Ministry of Health Services. A complete list of participating organizations has been included as Appendix A.

The purpose of each of these focus groups was to present the findings of the first round of consultation and provide an overview of the proposed approach. The focus groups provided participants from all affected organizations the opportunity to discuss the implications of the recommended process. Feedback from the sessions was incorporated into the model after each focus group meeting and forwarded to previous participants as a test for consistency. By the end of the second phase of consultation the volume of requested changes decreased. This process of iterative presentation and consistent feedback ensured that stakeholders would support the model and its elements recommended below.

2.2. Project Scope

A number of alternatives were declared to be out of scope of the study in an initial letter from the Minister of Health Services to affected stakeholders. Specifically, the Ministry did not wish to eliminate RHDs or to consider elected representation on Health Authority boards. Despite the fact these constraints were communicated to stakeholders at the start of this project, representatives from all five of the Health Authorities and approximately 30% of the RHDs indicated that they would support elimination of the RHD model.



This appears to be due in part to the fact that RHD representatives do not feel that they currently have sufficient input into the capital planning process to ensure accountability to their ratepayers. Furthermore, RHDs, with the exception of the Capital Regional Hospital District, do not employ dedicated technical staff qualified to participate in a meaningful way in the capital planning process. This is not to imply that RHD boards are not politically qualified to participate in decisions that affect their communities. It simply points to the fact that the withdrawal of the Ministry from the approval process creates the need for new processes to ensure effective decision-making.

In addition to these limits on project scope, the Minister also stipulated that there should be no increase in the overall historic funding ratios provided by the RHDs or require RHDs to assume new debt beyond historical and projected funding levels for traditional hospital capital projects. In other words, it was made clear that the new approach would not contemplate increasing the RHD overall historic funding applied to hospital capital. Finally, it became clear during the process that the Minister had also assured some RHD members and UBCM Health Committee members that the government had no plans to impose a property tax across the province to provide for health capital funding.

These constraints served to focus the project and the stages of discussion with stakeholders on an examination of processes, communications and relationships. As such, the constraints play a significant role in shaping the outcome.

2.3. Overview of Issues

Issues were collected from respondents among the stakeholder organizations through a range of avenues, largely dependent on the interest and experience of the participants. In general terms stakeholders treated the questions very seriously, focusing their comments around four main themes. From the beginning it was clear that there exists a strong commitment to the support and development of health services in the province.

The four main themes break down as follows, in order of importance and priority for the RHDs and Health Authorities:

- Issues related to accountability;
- Issues related to the definition of capital for the purposes of RHD cost sharing;

- Process issues; and
- Unique structural issues.

A more detailed catalogue of these issues can be found in Appendix B. An overview of each of these categories is provided below.

2.3.1. Accountability Issues

Ultimate responsibility for the provision of health care rests with the Ministry of Health Services and the Government of British Columbia. Public accountability for achieving stated health outcomes flows through the Minister to the Legislative Assembly. The Province has delegated practical implementation and delivery responsibilities to the five regional Health Authorities and the Provincial Health Services Authority. Performance and service level agreements between the Health Authorities and the Ministry of Health Services define expectations, performance deliverables and service requirements. In practical terms, then, the Health Authorities are the front line of service delivery. As appointed bodies, Health Authority boards do not have the authority to make decisions with respect to any potential taxation for health purposes.

RHDs were created in 1967 with the proclamation of the *Hospital District Act*. Their stated purpose was to establish a consistent approach to the funding of hospital projects. RHDs created consistency in approach, but they did not create an 'even playing field' with respect to levels of funding and resources available for investment in the health infrastructure. In practice, the role of the RHDs is to cost-share the capital costs associated with health facilities that operate under the authority of the *Hospital Act*. RHD contributions are collected as a levy against property in the Regional Hospital District. RHDs may borrow their share of the contribution from the Municipal Finance Authority.

The move to much larger Health Authorities means that health decisions and capital allocation decisions are made in the context of a much wider geographic area and a larger population than has ever been the case before. Many RHDs feel that the new Health Authorities are too distant to make decisions on behalf of local communities. Some RHDs feel that this creates a situation in which neighbouring communities are forced to compete with one another for limited capital resources. This group of RHDs often believes that it is their responsibility to lobby the Health Authority to ensure that they get their "fair share" of capital funding.

Some of these RHDs also believe that their existence is crucial to ensure smaller communities receive any services at all. Occasionally RHDs try to tie health capital to economic development, where the existence of health facilities is seen to be one means of attracting and retaining business and employees in a community, thereby ensuring the community's viability. However, this view is inconsistent with the Health Authorities' mandate and criteria for allocating health capital. It is also not consistent with the modern direction of health services development.

Historically RHDs have had major involvement with local hospital boards and usually participated on project building committees. A few RHDs still refuse to release funding to Health Authorities until they have reviewed and approved all of the invoices and receipts associated with a capital project or acquisition. While the mandate of the new Health Authorities does not

anticipate this level of RHD involvement in capital projects, it is likely that some RHDs will make their capital contributions contingent on the continued use of project building committees and associated processes. What remains is a situation in which relationships and processes must evolve to support the new environment in which capital allocation decisions are made. This process of evolution will determine the ultimate effectiveness of the system as a whole.

RHDs almost universally do not believe that they have sufficient input into capital decisions to meet reasonable tests of accountability to their ratepayers. Some Health Authorities are alleged to simply make a request for funding and expect the RHD to provide the money without any prior discussion of capital priorities and the health outcomes these capital projects are intended to support. This leaves RHD board members in a difficult and unfair position and creates a circumstance in which polarized opinions are likely to rise and negative decisions likely to flow.

RHD board members must respond to their ratepayers concerning the capital investment decisions affecting local facilities. They are also most likely to be directly approached by citizens with questions regarding capital issues, particularly when buildings are involved. While locally elected officials have a legitimate interest in the health of their communities, not all RHDs, or their residents, have a clear appreciation of the finer points of the distinction between capital funding and the delivery of health services. This sometimes leads to diverging expectations concerning the level of RHD influence over capital decisions and indicates a need for a clearly understood governance model to guide the capital cost-sharing process.

This reality also creates potential downstream issues as local representatives are elected and choose to use RHDs as the vehicle for general criticisms of the health services in BC. It is not obvious that it will always be possible to clearly distinguish between capital and service issues since capital investments will most often be made with improved service in mind.

It is imperative that each of the six Health Authorities have appropriate mechanisms in place to ensure public input as they plan, manage, and evaluate health care services to meet the priority population needs within their regions or mandate.

Health Authorities are aware there is a clear expectation by the Ministry of Health Services that processes for public and stakeholder consultation be established as they engage in planning. That expectation was conveyed to health authority chairs in a December 12, 2001, letter from Minister Hansen. The method by which this expectation is met has been left to the discretion of each individual health authority.

In response to the consultation requirement, health authorities have developed comprehensive health services redesign plans, which include communication strategies, to meet the needs of the population it serves.

2.3.2. Definition of Capital

As health care evolves, what is included in the definition of capital for the purposes of RHD cost sharing is changing as well. The traditional view of capital – hospitals and diagnostic equipment, was entirely appropriate in 1967 when the *Hospital District Act* was proclaimed. Best practices for delivering health services have created massive pressure for changes in models, as has the rapidly escalating cost of health services generally. No one in 1967 could have anticipated the manner in which modern Health Authorities would be delivering integrated health services.

As a result, there is at this stage no agreement concerning what should be eligible for RHD cost sharing and there is considerable variance in terms of what is actually being cost-shared by RHDs. In some locations, RHDs take a strict view of what they are willing to cost share, (interpreting legislation and regulation very literally) while in other places there has been greater flexibility, including the provision of funding for special projects that have no obvious connection to capital processes.

The modern health system relies heavily on information technology such as remote evaluation of diagnostic imaging, data transfer to improve rural access to specialists, BC Telehealth Program and increasingly sophisticated administrative systems for such things as electronic health records, financial management, logistics, scheduling and procurement. In the past the Province has not sought cost sharing on either patient/client or back office information technology. Nevertheless, some RHDs have voluntarily contributed to these systems.

There is a range of support among RHDs on the issue of cost sharing information technology projects. Some are very supportive while others see this as potential "downloading" of a provincial responsibility. The process of discussion leading to this report suggests that RHDs may be more likely to contribute to capital costs associated with patient/client information technology systems than to administrative systems such as payroll and financial management. Given the significant 'overhang' (essential projects that have been postponed in the past) of technology projects, there is likely to be significant pressure for cost sharing in this area.

The Ministry of Health Services requires Health Authorities to explore the option of a Private Public Partnership (P3) for any new facility or major project. Each P3 relationship will be unique, making it difficult to develop a standard process for cost sharing. However, given that the Health Authority may not hold title to the asset that is produced, the nature of any RHD contribution needs to be clearly defined for each project.

It should be noted also that the application of P3 approaches would be uneven across the Province since the opportunities will vary. At a minimum, there will be some requirement to define the treatment of contributions to P3'd projects in such a way as to ensure that a linkage between any RHD contribution and public ownership or control of some part of the asset is maintained.

2.3.3. Process Issues

A lack of standardized processes means that there is no consistency among the five regional Health Authorities and their associated RHDs. In general, communication between the Health Authorities and the RHDs has been poor, creating a situation of mistrust in some areas. This will require considerable effort to reverse. Although most Health Authorities have undertaken the negotiation of Memoranda of Understanding (MOUs) with their RHDs, to date none have been signed off by all the parties.

The protocols described in these documents have significant merit. Essentially, they are local expressions of relationships and commitments to common processes and practices to be followed by the Parties. It is not surprising that the system has been challenged to produce documents that are agreed to by all the RHDs involved with a Health Authority since there are significant differences of scale, taxation capacity, wealth and population. In addition, there is significant variation in past experience relating to health institutions and how capital costs are shared across a region. What is clearly seen as a desirable process by many stakeholders should be encouraged to flourish at the more local level. There may be significant advantage in creating MOUs that involve even a single RHD and its Health Authority if that means giving reality to a longer-term more effective and enduring relationship.

The Ministry of Health Services has reduced significantly its level of involvement with RHDs. The Ministry no longer approves RHD budgets and bylaws and no longer has a role in prioritizing the capital projects proposed by the Health Authority. Health Authorities generally find current processes cumbersome and inefficient and believe the amount of administrative time spent negotiating with RHDs is excessive given the size of the RHD capital contribution relative to their overall budgets.

RHDs throughout the province appear to have many different perspectives of their role in the capital process and some are involved in activities that might be seen as outside of their intended mandate or detract from the efficiency of the current processes from the point of view of the Health Authorities. Special issues exist for Fraser and Vancouver Coastal Health Authorities since only relatively small parts of their population base are represented by RHDs.

The coordination of budget cycles has been a problem as Health Authorities have a fiscal year-end of March 31, while RHDs have a December 31 year-end. This has sometimes created delays for the Health Authorities as they must often wait for RHD approvals to release funds, potentially causing cash flow problems on some projects. The budget cycle differences sometimes create frustration for RHDs because they fail to receive timely financial information.

2.3.4. Structural Issues

A number of structural issues were identified during the consultation phase. Most of these issues are unique to a specific area and do not affect the recommended cost-sharing model. The following issues have been addressed in more detail in the Issues Summary.

Areas not represented by RHDs

Provisions in the *Greater Vancouver Transportation Act* resulted in the elimination of the RHD within the Greater Vancouver Regional District, but maintaining approximately the same taxation level for transportation purposes. This area represents more than half the population of the province, which creates a unique set of issues for the four coastal RHDs at the northern end of the Vancouver Costal Health Authority and Fraser Valley Regional Hospital District, the only remaining RHD in the Fraser Health Authority.

RHDs with no tax base

Some RHDs, such as Central Coast Regional Hospital District do not have a sufficient tax base to contribute to capital projects. Although in practice RHD participation in capital projects is voluntary and ultimately dependent on the fiscal capacity of the region, the Health Authority is responsible for providing health services regardless of the region's capacity to pay for them. This reality creates significant issues for the Health Authorities insofar as their ability to deliver against service goals and targets may be dependent on projects that cannot receive local cost sharing.

RHDs in more than one Health Authority

The Cariboo-Chilcotin Regional Hospital District straddles the boundaries of both the Northern Health Authority and the Interior Health Authority. This is inconsistent with the rest of the province and may have the effect of creating administrative inefficiencies. At a minimum it creates a need for a doubling of participation by the RHD. The two impacted Health Authorities may find that the RHD is forced to focus its activities in the alternative Health Authority's area. Effectively, this arrangement creates another, potentially complex, pre-condition to the capital planning processes in the Interior and Northern Health Authorities. Adherence to the general principal of simplification would suggest that this arrangement would be subject to some examination downstream.

Patient referral patterns

This creates special problems for the Northern Health Authority since residents in the northeast are more likely to be referred to Alberta to access services, while residents in the northwest are more likely to be referred to Vancouver. Although Prince George has been designated a regional centre, Prince George is difficult to access for most northern residents. These referral patterns create special challenges for NHA in building sound relationships with its RHDs. A somewhat similar problem exists for the Interior Health Authority since residents in the extreme southeast of the province (Cranbrook, Sparwood, Fernie) may have to be referred to Calgary to receive timely medical treatment.

Cross-Boundary Cost-Sharing

Some regional centers, such as the Capital Regional Hospital District, have chosen not to pursue cross-boundary cost sharing, believing that the economic benefit of being a regional centre outweigh the cost of providing regional services. In other regions, two or more RHDs have successfully negotiated cost-sharing arrangements for capital projects in regional facilities that benefit residents of the broader community.

Cross-boundary cost sharing arrangements have been voluntary and Health Authorities have not been involved in the negotiation. However, a lack of standard guidelines has made it difficult for RHDs to find an equitable cost-sharing formula. In practical terms, a number of discrete variables come to play when considering cross-border capital projects. Additional complexity rises from the fact that fiscal capacity and historical contribution levels may vary between adjacent RHDs whose citizens benefit from a regional capital investment.

RHDs with large on-reserve First Nations populations

In the past there was a direct link between the funds for health capital transferred by federal government on behalf of on-reserve First Nations communities and actual expenditures. At present these funds are contained in the Health and Social Transfer Payment made to the Province, some portion of which flows through the Ministry to the Health Authority although it would be difficult to follow this trail. Like the Provincial Government contribution to health capital projects, these amounts cannot be traced. As such, they become 'nominal' contributions, with a value that equals the value of previous federal contributions. RHDs are concerned that there is no evidence of a "local" contribution being made from federal funds in these areas.

2.4. Guiding Principles

In contemplating a system to address the issues outlined above, it is useful to apply some fundamental principles that can be used as design criteria. The four guiding principles were established to guide the development of the recommendations provided in this report. These principles are discussed in descending order of significance.

2.4.1. Taxation and Accountability

Accountability to ratepayers is a fundamental principle of a democratic government. RHD boards are composed of elected representatives who have been granted the authority to levy taxes against property for the purpose of funding capital projects. The principle of accountability therefore requires that RHD boards have input into the decisions about how these funds are spent. This principle also requires that RHDs receive adequate reporting information from the Health Authority as to how the RHD funds have been allocated.

2.4.2. Consistent with Modern Health Services

Any new capital funding model must be supportive of the health delivery mandate of the Health Authorities and consistent with best practices in the development of modern health services. Health Authorities must request capital funding for projects that meet these basic objectives while RHDs assist in funding the capital assets necessary to provide appropriate health services. This means that the system must provide greater flexibility to Health Authorities and RHDs to partner in the construction and maintenance of a variety of different types of facilities, equipment and infrastructure to best meet community needs.

2.4.3. RHD Contribution Limitations

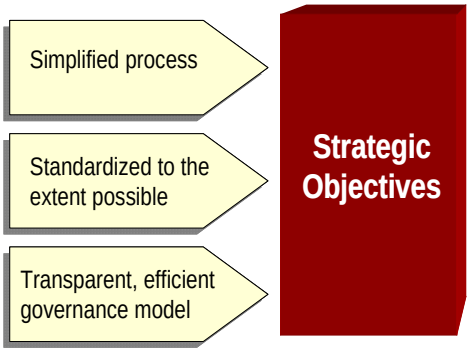
Not all RHDs can generate the resources required to contribute to capital projects, or to contribute the entire 40%. The Health Authority has the responsibility to ensure that health services are available to the residents of these regions regardless of their ability to pay. The new capital funding model must be sensitive to these facts and provide opportunities for regions to contribute according to their ability to pay.

Although current legislation prohibits the Province from paying more than 60% of the cost of capital projects (through its capital transfers to Health Authorities), some RHDs may not be able to contribute as much as 40%. The new model should provide sufficient flexibility to allow the Health Authority and the RHD to negotiate an equitable cost sharing agreement. Such agreements or MOUs must ensure that a reasonable level of equity in capital funding provided by RHDs prevails across the Province, tempered by the local ability to pay.

It should be noted that there is significant variation in the level of annual local contribution for health capital projects across the province, with rates per $100,000 of assessed value ranging from an apparent low of $13 to a high of $75. Often, some portion of the taxed amount is needed to retire old debt or offset future debt. Participants in our discussion tended to use this approach to calculating contribution levels. Clearly others can be used and these data alone are not sufficient to explain decisions associated with contribution levels. It should also be noted that a detailed review of contribution levels across the province lies outside the scope of this study. Health Authorities and their associated RHDs may wish to examine their local conditions with respect to contributions.

2.4.4. Contributions must benefit the Local Community

Similar to the principle of accountability, this principle requires that funds raised through property taxation must be used for capital projects that directly benefit the residents of that community. RHDs therefore need to have evidence that their contributions are directly tied with local capital projects. This requirement creates a reporting onus for Health Authorities that must be taken very seriously.



In the case of regional referral facilities, residents from other RHDs benefit from the use of regional referral facilities, while those may have been subject only to capital contributions by the RHD containing the regional facility. Health Authorities and RHDs will most likely find individual solutions to such issues and will discover the ground on which regional facilities are cost-shared.

2.5. Strategic Objectives

In addition to the principles defined above, a number of strategic objectives emerged. These objectives address many of the organizational or tactical issues identified during the consultation process.

- **Simplified process** - many stakeholders indicated a desire for a simplified process. High-level guidelines will help coordinate expectations by clarifying roles and responsibilities.
- **Standardized to the greatest extent possible** - standardization does not preclude Health Authorities and RHDs from tailoring processes to meet local needs. Standard processes established in Ministry policy can be augmented with local MOUs outlining local variations.
- **Transparent, efficient governance model** - a transparent governance model is necessary to ensure accountability and to provide certainty necessary for long-term planning. This will assist all stakeholders including the public to understand the roles and responsibilities of each of the parties.

3. RECOMMENDED APPROACH

This project did not result in a number of discrete options. Instead, what emerged was a new approach that contained several components. Each of these components evolved over time in consultation with stakeholders. The model presented below represents the product that emerged after extensive stakeholder input. While it is not possible to argue that there is a perfect consensus regarding these recommendations, it is clear that all stakeholders who had an interest in participating and shaping the outcome are represented in some form.

The following sections outline a working definition of capital for the purpose of RHD cost sharing, a standardized capital planning process, a preliminary implementation strategy and a discussion of expected outcomes.

3.1. Definition of Capital

Sierra Systems recommends maximum flexibility in defining capital items that are eligible for RHD cost sharing. Priorities will continue to be established by Health Authorities according to health needs in a manner that respects the RHDs ability to contribute as well as their fundamental need for accountability. RHDs will continue to have the option to decide whether or not they can contribute and at what level.

For the purposes of RHD cost sharing, the categories of capital should be simplified to two categories:

- Projects or single pieces of equipment with a value of less than $100,000
- Projects or equipment with a value greater than $100,000

These categories include equipment and facilities, including projects such as - acute care hospitals, diagnostic and treatment centres, extended care facilities and multi-purpose facilities as well as Client/Patient information technology projects.

Currently, Interior Health Authority uses a $150,000 cut-off level below which items are classed as ‘minor’ capital. This new level was considered appropriate, but ease of administration suggests that the existing level be maintained. Rules set by the Auditor-General, under which the Ministry operates, require that any capital item to which Ministry funds are applied that has a value less than $100,000 should be expensed and not treated as capital assets by the Province. On balance, it appears easiest to adhere to those guidelines. It is the case, however, that recognizing the accounting complexity that may be created by the use of a higher limit (for example $150,000) such an option could be taken at the local level.

Many of the projects fitting the larger of the two categories hold the potential for P3 approaches in some parts of the province. This approach may not easily allow capital to be acquired for smaller items. It should also be noted that large information technology projects allow for the use

of P3 tools. Patient client systems tend to be very expensive and are difficult to extract savings from because of the propensity of health services to readily soak up and re-deploy notional savings. On the other hand, back office IT projects frequently contain the potential for significant savings, thereby holding out the possibility for P3 approaches.

In any case, the Ministry, in consultation with the appropriate accounting authorities, should ensure that the ownership of capital assets is clearly defined. This definition must specifically address RHD contributions in order to create comfort among RHD Boards that capital contributions funded from the local property tax base remain in the public domain.

For the purposes of RHD cost sharing, the categories of capital should be simplified:

- **Projects or single pieces of equipment with a value of less than $100,000**
- **Projects or equipment with a value greater than $100,000**
- **The classification of equipment value must take into account the overall value of a 'system' of which a single piece of equipment is a part**
- **P3's require the development of clear accounting definitions to recognize ownership.**

Recommendation 6

3.1.1. Absolute Contribution Levels

It is not anticipated or desired that this change in the definition of capital will increase the overall ratio of financial contribution of the RHDs or require RHDs to assume new debt beyond historical and projected funding levels for traditional hospital capital projects. Rather it will help maximize the flexibility of the funding partners in providing the facilities and equipment required to deliver the appropriate level of health services to the residents of British Columbia. This broadened scope of eligibility of capital for the purposes of cost sharing must respect the fundamental principle that the demand for local capital contributions must not exceed the region's capacity to pay.

A change in the definition of capital should not increase the overall ratio of financial contribution of the RHDs or require RHDs to assume new debt beyond historical and projected funding levels for traditional hospital capital projects.

Recommendation 8

Beyond the constraints of local capacity, demand will also be constrained by the need for Health Authorities to fund the balance of the demand. Health Authorities will continue to prioritize projects according to need and the availability of finite resources. This reality will assist in providing a balance against the increase in the number of types of project eligible for cost sharing. It should be noted that this model creates checks and balances to ensure that increases in the actual amount of RHD cost-sharing across the province or within any Health Authority can only occur as a result of the voluntary decisions of RHDs.

3.1.2. Allocation Decisions

RHDs should allocate lump-sum contributions to minor items below $100,000.

Recommendation 7

The minor capital threshold of $100,000 is consistent with the Auditor General's definition of capital and represents a significant portion of the Health Authorities' capital budget. Some RHDs currently provide a lump-sum grant to the Health Authority for expenditures under $100,000, while other RHDs do not contribute to these expenditures at all, electing instead to focus their contributions on larger projects. In at least one case, a Health Authority reported that no money for minor items was requested from an RHD on the basis of the proposition that the Health Authority should deal with its own minor capital demands and turn to the RHD for major projects and equipment.

Sierra Systems recommends that RHDs allocate lump-sum contributions to these minor capital items. This would simplify the allocation decision and would provide the Health Authority with a relatively stable RHD contribution from year to year. In order to meet accountability requirements, the Health Authority would be expected to provide a list of anticipated minor capital acquisitions to the RHD at the joint planning meeting (created in the process described below) and report back on actual acquisitions later in the year. This respects the Health Authority's mandate to deliver health service and avoids the potential for debate over individual line items.

3.2. Capital Planning Process

The following sections outline a process that addresses the issues identified by stakeholders and satisfies the guiding principles and strategic objectives identified earlier in this report. The recommended model is based on a 5-year rolling capital plan and a standardized communication process that allows for the timely exchange of information and an opportunity for RHD participation. A longer-term planning horizon will greatly improve communication and coordination between the Health Authorities and the RHDs.

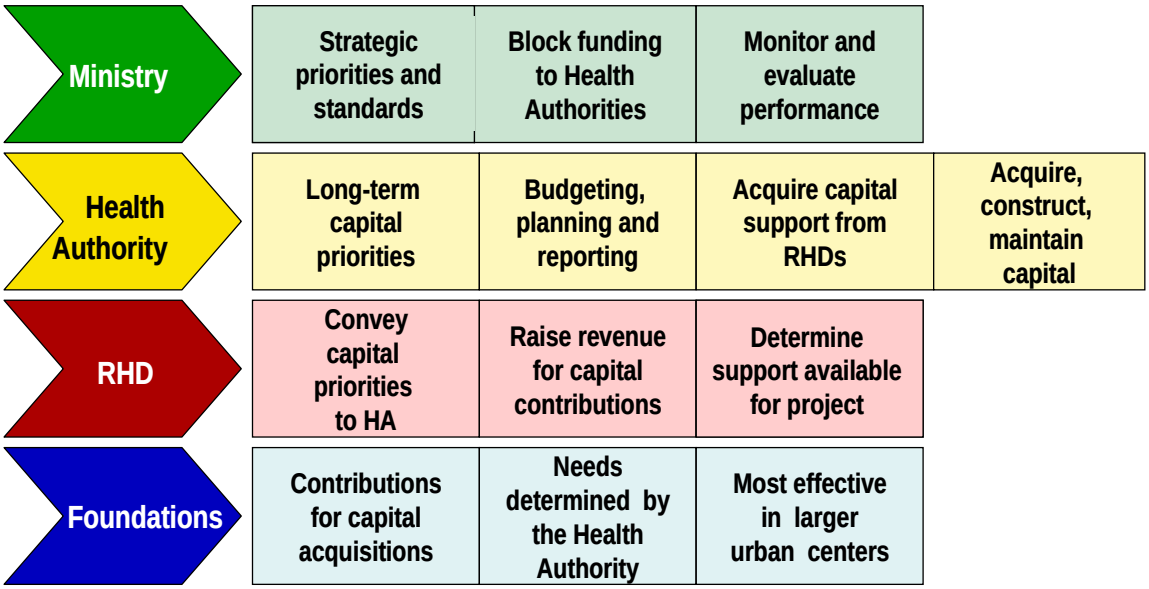
Health Authorities should move towards a 5-year rolling capital plan and a standard communication process.

Recommendation 10

The recommended process is based on a limited number of activities that take place at key times throughout the year. However, this standardization is not meant to displace local processes, especially in the north where communication needs are quite unique. It is anticipated that the standard process would be augmented by local variations that may be documented in one or more memoranda of understanding.

3.2.1. Roles and Responsibilities

Partners in the capital planning process need to have a clear understanding of their respective roles for the proposed process to work effectively. The following table outlines the recommended role for each of the partners in the capital planning process.



Ministry of Health Services

The Ministry establishes high-level health outcomes and provides the Health Authorities with the resources necessary to meet these objectives. Health Authorities are held accountable to the Minister through a performance contract that includes specific performance targets that can be monitored. If a Health Authority fails to meet the outcomes established in its performance agreement, the Ministry has a responsibility to ensure that the situation is corrected.

Health Authorities

The Health Authority is responsible for developing long term capital plans based on the health needs of the region and other capital priorities, including maintenance schedules and equipment deficiencies. Priorities must be established in the context of finite capital resources provided by the Ministry. Although Health Authorities are able to borrow funds for capital projects with Ministerial approval, debt servicing must come out of the Health Authorities' operating budget.

Based on these priorities, the Health Authority must develop budgets and plans to construct, acquire and maintain capital assets. The Health Authority is also required to report back to the Ministry and to RHDs as to how public resources were spent and how these expenditures contributed to various health outcomes. Reports should clearly indicate RHD contributions and how they were used.

The Health Authority must develop budgets and plans to construct, acquire and maintain capital assets.

Recommendation 4

The Boards of the Health Authorities are not elected and therefore do not have the statutory or moral authority to levy taxes or requisition funds directly from RHDs. As the Ministry does not intend to change the composition of the Health Authority boards, participation of RHDs in the capital funding process will remain essentially voluntary. Therefore, it becomes the responsibility of the Health Authority to work with the RHDs to acquire the financial support necessary for capital acquisitions and projects. This will require developing and maintaining effective working relationships based on open communication, timely exchange of planning information and trust.

Budgetary overruns or delays should become the responsibility of the Health Authority. RHDs may still choose to help fund overruns.

Recommendation 5

Finally, it is the responsibility of the Heath Authority to oversee the acquisition, construction and maintenance of capital assets. This suggests that budgetary overruns or delays would become the responsibility of the Health Authority. In cases where a project overruns its original budget Health Authorities may wish to request additional contributions from RHDs.

Regional Hospital Districts

The role of RHDs is to participate in the provision of capital assets required to deliver health services considered necessary by the Health Authority and to communicate their sense of local capital priorities with Health Authority staff. The process for communicating local input is outlined in the recommendations section of this report. The mechanism through which the RHD receives information from its ratepayers about local priorities is entirely up to the RHD. However, Health Authorities must base local capital priorities on proven and prioritized health needs. In some cases, the community's views may diverge from the Health Authority's capital priorities.

RHDs should not be expected to contribute more than 40% of new projects.

Recommendation 3

This mandate does not contemplate RHD participation in Health Authority decisions regarding delivery of health services. This distinction between the RHDs role in the capital planning process and the Health Authority's mandate for service delivery will help alleviate widely divergent expectations**.** This will allow each party to focus its efforts on the activities that add maximum value to the process thereby avoiding inefficiencies and process.

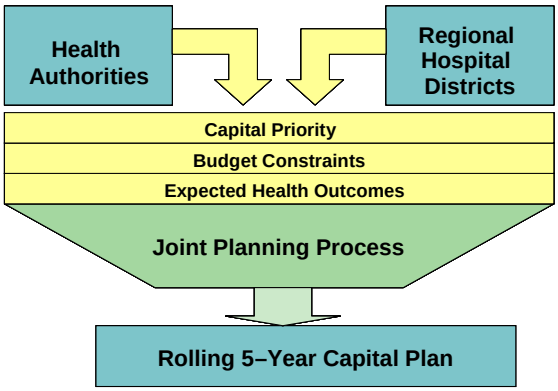
The RHD must then determine how much the region is able to contribute to the capital projects and communicate that information to the Health Authority. RHD capacity should be based on the relative fiscal capacity of the region and should consider existing health related debt servicing costs.

Hospital Foundations

Hospital foundations contribute a significant portion of the overall capital budget in many communities. Foundations tend to be more effective in more affluent areas where there is significant commercial or industrial concentration. Foundations typically work with the Health Authorities to determine community needs and then implement a campaign to fund a particular facility or piece of equipment.

3.2.2. Communications

Since the creation of the five regional Health Authorities, communication between Health Authorities and RHDs has been insufficient in most cases. The success of the recommended cost-sharing model will depend on significant improvement being made in this area. As the principle of accountability requires that RHD contributions be essentially voluntary, the onus rests with the Health Authority to develop and maintain effective working relationships with the RHDs in its region.



The exchange of information will have to be sufficiently complete and timely to encourage RHDs to contribute some portion of the capital costs anticipated by the Health Authority. Failure to do so could result in a breakdown of communication with the RHDs, making capital contributions from RHDs more difficult to acquire. This model assumes that both parties will continue to act responsibly throughout the capital planning process and will make decisions in the best interest of their residents.

Although RHD contributions are voluntary, to ensure equity, RHDs should be strongly encouraged to contribute what they can afford. Regional capacity must consider current and future year's contributions as well as the debt servicing cost from prior years. Contribution levels would therefore reflect those of other RHDs with equivalent assessment bases receiving similar levels of capital investment.

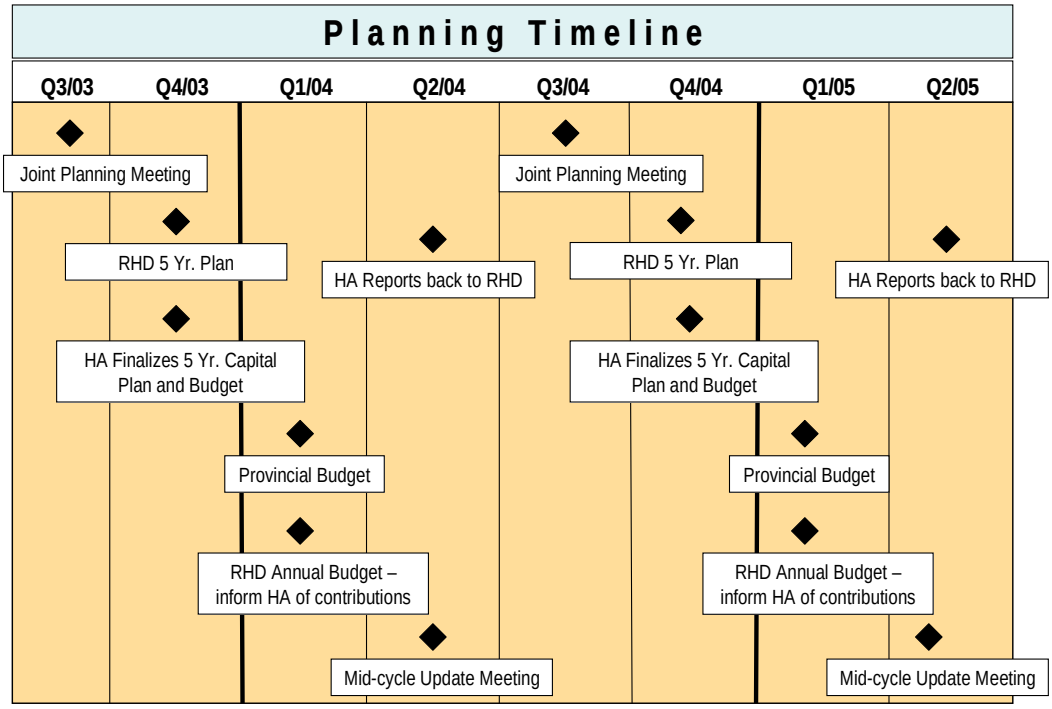
RHD contributions are voluntary. The onus rests with the Health Authority to develop and maintain effective working relationships with the RHDs in its region.

Recommendation 1

As the principle of accountability requires that RHD contributions be essentially voluntary, the onus rests with the Health Authority to develop and maintain effective working relationships with the RHDs in its region. RHDs will encourage good relations by being reliable funding partners. Similarly, Health Authorities will encourage good relations by enhancing their ability to share data and information.

3.2.3. Planning Timeline

The following timeline outlines the proposed capital planning process over a period of eight quarters, spanning three calendar years. The process begins in the third quarter of Year 1.



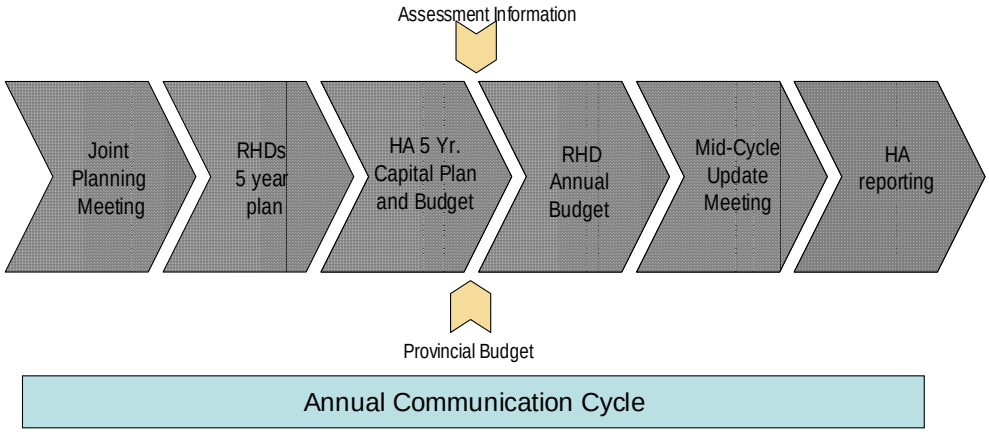
The planning process outlined in this report is cyclical in nature and is tied to a number of events that occur at fixed times throughout the year, including the announcement of the provincial budget, delivery of the local government assessment information and the planning and budget deadlines for the Health Authorities and RHDs. The cyclical process will eliminate the coordination issues that arose in the past due to insufficient information and overlapping fiscal years.

A regular cyclical process is recommended to eliminate coordination issues

Recommendation 14

3.2.4. Annual Joint Planning Meeting

In some areas Health Authorities and RHDs have started developing an interactive planning process that involves regular meetings, but this is not the case in most regions. In order to solidify relationships and develop processes based on a shared understanding of each party's appropriate role, a formal meeting schedule needs to be implemented. The following diagram outlines such a process.



In the fall, before Health Authority and RHD budgets are finalized a joint planning meeting (or series of meetings) would be held to discuss the content of the Health Authority's five-year capital plan. This meeting would be attended by elected and appointed representatives of the RHDs and local Health Authority staff, most likely the local Chief Operating Officer, or equivalent.

The purpose of this meeting is to give RHDs the opportunity to have input into the plan and the capital planning process and to discuss local priorities with the Health Authority. Therefore the Health Authority plan cannot be finalized prior to the joint planning meeting. Some flexibility will be needed in the first of the planning meetings contemplated for the Fall of 2003 since Health Authorities will have created relatively firm plans for the first year of the five-year plan. This should not be an issue downstream.

The joint planning meeting should be used to meet education objectives by providing an opportunity for the Health Authority to explain its planning assumptions as well as the specific health outcomes that it is pursuing.

Recommendation 12

The joint planning meeting would also fulfill an education objective by providing an opportunity for the Health Authority to explain its planning assumptions as well as the specific health outcomes that it is pursuing. Although information is available in published Health Authority plans and on the Internet, more effort is required to communicate these priorities with planning partners. RHDs need to understand how capital investment supports specific local health outcomes in order to make informed decisions and be accountable to their ratepayers.

Better communication earlier on in the process will allow RHDs to anticipate future based contributions as they will know several years in advance when they will be beneficiaries (and contributors) of local capital investment. This gives them the opportunity to develop reserves for that purpose or take whatever measures necessary to manage their budget process according to local priorities.

The agenda for these planning meetings may include the following:

- An overview of the health outcomes contained in the Health Authority's performance agreement with the Province
- The Health Authority's strategy for achieving these outcomes
- 15-20 year "landscape" forecast of the regions capital requirements
- Details of the Health Authority's proposed 5-year capital plan
- Discussion of the assumptions underlying this plan
- Discussion of local capital priorities, by RHD
- Overview of RHD planning constraints, including outstanding health-related debt, local assessment base and current local government taxation levels
- Formalization of proposed process to meet local communication needs (MOU)

In the fall, before Health Authority and RHD budgets are finalized a joint planning meeting (or series of meetings) should be held to discuss the content of the Health Authority's five-year capital plan.

Recommendation 11

3.2.5. Mid-cycle "Reality Check" Meeting

By early spring, Health Authorities and RHDs will have received information including the provincial budget that identifies the funding allocation to Health Authorities and property assessment information from the BC Assessment Authority. This information may impact the ability of the Health Authority or the RHD to meet the tentative commitments that were made at the joint planning meeting the previous fall. Furthermore, new priorities may emerge as a result of unanticipated capital needs in specific facilities. The purpose of the mid-cycle meeting is to review the five-year capital plans and discuss any necessary amendments.

The mid-cycle meeting reviews the five-year capital plans and discusses any necessary amendments.

Recommendation 13

During this meeting the Health Authority would also report back to the RHDs on the prior year's capital expenditures. At a minimum this would include a list of expenditures and acquisitions by RHD. The local Health Authority and RHDs should determine the level of additional detail required.

This meeting should occur in the second quarter in order to provide sufficient time for the Health Authority Board to review and approve

the 5-year capital plan by March. This would also give the RHD time to incorporate financial contributions into its budget prior to the March 31 deadline.

3.3. Preliminary Implementation Strategy

Effective integration of the processes outlined in this report may occur over several cycles. Therefore Sierra Systems recommends that implementation of the recommended process begin in the fall of 2003 with a joint planning meeting between Health Authorities and RHDs. The earlier the Health Authorities and RHDs begin working together, the sooner the long-term capital plans and communication protocols can be established. Health regions can then begin developing local variations to the process to suit local needs along the way. This process reflects the direction anticipated in several health regions as documented in preliminary MOUs. For other health regions this process will be a significant departure from the status quo and will require a period of learning and adjustment. Furthermore, in the first cycle neither party will have all the information necessary to participate fully in the joint planning process. As a result, the first year's planning information may not be as flexible as an ideal model suggests.

Implementation of the recommendations process should begin in the fall of 2003 with a joint planning meeting between each Health Authority and its RHDs.

Recommendation 9

The new cost-sharing model documented in this report should be presented to the Regional Hospital District session at the fall convention of the UBCM. The Ministry will have to prepare some legislative amendments and to engage in policy formulation over the summer. Facilitation support may be required for the first set of planning sessions to guide stakeholders through the process and to help them to start developing effective communication protocols.

The Ministry of Health Services should review the capital cost sharing process three years after implementation to assess whether the Health Authorities and RHDs have developed effective working relationships and are fulfilling the intent of these recommendations.

3.3.1. Legislative Amendment

The *Hospital District Act* was amended in spring 2003 to remove ministerial control over RHDs. The initiative was narrow in scope and the exercise needs to be completed. Further legislative amendment will also be required to modernize the legislation from an administrative perspective and to support the processes outlined in the recommended cost-sharing model. Legislation should be amended to reflect the role of the RHD under the new model, which is to:

Specific reference to *"hospitals and hospital facilities"* should be replaced with a broader definition of what is eligible for cost sharing.

Recommendation 15

- Represent the RHDs interests in the capital planning process and to work with the Health Authority to establish capital priorities;
- Determine the level of support available for capital projects sponsored by the Health Authority, and
- Raise revenue for health capital contributions to assist the Health Authority.

The purposes of RHDs are outlined in Section 20 of the *Hospital District Act* which created RHDs to provide funding for the establishment, acquisition, construction, reconstruction, enlargement, operation and maintenance of hospitals and hospital facilities defined under the *Hospital Act*. Legislation should be revised to provide a cost-sharing model that reflects the modern delivery of health services and is consistent with the definition of capital provided in Section 3.1 of this report.

Specific reference to "*hospitals and hospital facilities*" should be replaced with a broader definition of what is eligible for cost sharing. RHDs should be given broad legislative authority to choose to contribute capital funding to any equipment or facility deemed necessary by the Health Authority. Ministry policy should then define capital for the purposes of cost sharing. This definition would include, for illustrative purposes, equipment and facilities such as:

- Acute care hospitals;
- Diagnostic and treatment centres;
- Complex, multi-purpose and extended care facilities;
- Client/Patient information technology projects; or
- Any other project permitted by Ministry of Health Services as defined in Ministry policy.

Health Authorities must be unfettered by cost-sharing requirements in their ability to provide required health services regardless of the fiscal capacity of a region.

Recommendation 2

Some functions described in this section are no longer relevant, including subsections (d) and (e), which involve "*acting for the agent of the government in receiving and disbursing money granted by the hospital insurance fund*" or "*acting as the agent of the hospital in receiving and applying money paid to the hospital by the government of Canada*."

Legislation currently restricts Health Authorities from undertaking capital projects if an RHD is unable or unwilling to cost share. Health Authorities must be unfettered in their ability to provide required health services regardless of the capacity of the region's revenue base. To ensure the Health Authority is able to fulfill its mandate, this restriction should be removed from the legislation.

Both the *Hospital District Act* and the Regulations to the *Hospital Insurance Act* should be amended so that it does not restrict the Ministry (and by implication the Health Authorities) in terms of a predetermined cost-share ratio for capital projects, with the possible exception of large projects in urban centers or facilities being acquired through public private partnerships. Other reference to specific percentages in the *Hospital District Act* and the regulations to the *Hospital Insurance Act* should be deleted and replaced with more flexible language.

The recommended model is based on a 5-year capital plan for the RHD, which would supplant the requirement for the RHD to submit a provisional budget to the Ministry. Section 23 of the *Hospital District Act* requiring that the RHD submit a provisional budget should be amended to be consistent with the legislated requirements for the financial administration of Regional Districts. It is suggested that legislative requirements for Regional Districts be considered when reviewing the RHD financial administration requirements. Where feasible and practical, the objective should be to achieve consistency between the Regional District and RHD processes.

3.4. Anticipated Outcomes

The proposed model is the culmination of an iterative process that involved two phases of stakeholder consultation. Although it would be difficult to say that a consensus now exists, it is reasonable to assume that stakeholders that have participated in the development of a model are more inclined to give it an opportunity to succeed. However, it may take several years for the new process to reach its full potential. This will require a period of learning as participants come to understand the constraints and objectives of the other parties to the process.

The new cost-sharing model is intended to provide a balance between standardized processes and the incorporation of local variations. This will result in a system that can be tailored to meet the specific communication and/or process needs of a region. This will be particularly important in the north where the culture and geography sometimes require a specialized approach. Regional variations may be formalized in one or more Memoranda of Understanding.

The proposed model also provides maximum flexibility with regard to the type of capital that can be cost-shared, thereby ensuring a capital funding process that is consistent with the delivery of modern health services. The new model also respects the Health Authorities' mandate of establishing capital priorities according to health needs while at the same time providing an opportunity for RHDs to participate in funding capital assets that provide benefit to their communities. This will be accomplished in a manner consistent with its fundamental need for accountability and the RHD's capacity to pay.

Clearly defined roles and responsibilities will facilitate an effective two-way communication and planning process and will help Health Authorities and RHDs develop effective working relationships. This will allow each party to focus its efforts on the activities that add maximum value to the process thereby avoiding inefficiencies and process.

The longer term planning horizon overcomes issues related to fiscal year ends and over time will provide greater certainty and an improved ability to forecast for both the Health Authority and the RHD. A cyclical process based on a 5-year rolling capital plan will provide greatly improved coordination of planning and budgeting and will ensure that both elected and appointed bodies are able to meet their accountability requirements regarding the expenditure of public funds.

Appendix A. Acknowledgements

Capital Cost Sharing Review Steering Committee

Tamara Vrooman (Chair)	Chris Mazurkewich
Barry Cheal	John Heath
Susan Gimse	Al Richmond
Rich McDaniel	Christopher Causton

And support staff

Jo-Anne Allbutt	Chris Sullivan
Jeremy Tate	Susan Murphy
Harriet Permut	Lynn Paterson
Judy Tracy	Dave Mackintosh
Gerry Slykhuis	

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Vancouver Island Health Authority
Vancouver Coastal Health Authority
Interior Health Authority
Northern Health Authority

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Alberni-Clayoquot
Capital
Cariboo-Chilcotin
Central Coast
Central Okanagan
Comox-Strathcona
Cowichan Valley
Fraser-Fort George
Fraser Valley
Kootenay East
Mount Waddington
Nanaimo
North Okanagan-Columbia Shuswap
North West
Northern Rockies
Okanagan-Similkameen
Peace River
Powell River
Sea to Sky
Stuart-Nechako
Sunshine Coast
Thompson and
West Kootenay-Boundary