Ministry of Health Services

Regional Hospital District Cost Sharing Review

Issues Summary

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1. INTRODUCTION

This document represents a comprehensive catalogue of issues that were identified during two consecutive phases of consultation for the RHD Cost Sharing Review. This phase of consultation involved representatives of Regional Hospital Districts, Health Authorities, the Union of BC Municipalities Health Committee and the Ministry of Health Services.

Information from the Health Authorities and RHDs was gathered using a standard survey questionnaire. RHDs responded in a number of ways, including telephone conference calls, one-on-one telephone interviews and written submissions. Some organizations prepared extensive briefing materials and discussion papers on the subject of cost sharing. Representatives of Health Authorities were interviewed either by telephone or in person. Ministry staff and members of the UBCM steering committee were also involved in this phase of information gathering.

A draft of this document was then circulated among the individuals who would be participating in the second phase of consultation that consisted of a series of seven half-day focus groups held in locations throughout the province. Additional issues that were raised during the focus group meetings have subsequently been incorporated into this document.

Some of the issues listed in this document were raised by many organizations, while others appear to be of interest to only a few. The recommendations presented in the main document addresses most of the issues of universal concern. Other issues, although relevant, could not be resolved in the context of this project and may require action by the Ministry of Health Services.

By the end of the first phase of the consultation, every RHD and Health Authority had been given the opportunity to participate and although the quantity varied, information was received from almost every stakeholder organization.

1.1. Types of Issues

Once each organization had been given the opportunity to provide input, the issues were analyzed and categorized. Issues generally fell into the following four categories:

- Accountability
- Definition of Capital
- Process Issues
- Structural Issues

These categories are explored in more detail throughout the following sections.

2. ACCOUNTABILITY

2.1. Health Authorities

- Health Authorities are mandated to provide health services and the line of accountability flows to the provincial government. Ultimate accountability for the provision of health services by the Health Authority rests with the Minister of Health Services and the government of the day.
- Health Authorities have also developed health services redesign plans outlining how they intend to achieve the Province's strategic priorities and New Era goals of providing high quality patient-centered care, improving the health and wellness, and creating affordable and sustainable health care. These plans are used as the basis for discussion to ensure ongoing improvement in the health system.
- Health Authorities have been mandated to make decisions regarding the allocation of health resources based on health needs and are often uncomfortable having these decisions questioned by RHDs. Health Authorities are more focused on the "big picture" and have to make scientific decisions on behalf of their entire region, while RHDs are focused on their individual communities and constituents.

2.2. Regional Hospital Districts

- Regional Hospital Districts are made up of locally elected representatives, while the Minister of Health Services appoints Health Authority boards. All RHD representatives are members of Regional District boards, either by virtue of having been appointed by their municipal councils or by being directly elected as Electoral Area Directors in unincorporated areas outside of municipalities. Some RHDs contain members from more than one regional district.
- The fundamental principle of accountability suggests that some influence over the allocation of locally taxed funds is required to ensure local accountability. Many RHD representatives are frustrated with their lack of input in establishing the capital priorities of the Health Authorities.
- RHDs expect a direct linkage between local capital contributions and benefit to the community. This has implications for cross-boundary cost sharing for regional referral facilities. There have been at least two competing legal opinions sought to clarify whether or not the legislation allows RHDs to contribute to projects that are not within their boundaries.
- With the consolidation of Health Authorities, local residents may no longer have easy access to Health Authority Board members within their communities. This has placed an additional burden on local elected officials who are questioned by constituents regarding changes to health care – often regarding issues that are not within the mandate of the RHD. There is a general lack of understanding of the role and mandate of the RHD among the public that may create political difficulties for local elected officials.

3. DEFINITION OF CAPITAL

Since their inception, RHDs have generally contributed to the construction and maintenance of acute care and diagnostic and treatment facilities. This definition of capital was entirely appropriate in 1967 when the legislation was introduced.

Modern health care has shifted the focus away from "hospitals" toward integrated "health services". The definition of capital needs to reflect the current and future vision of the Ministry of Health Services and the Health Authorities with regard to the delivery of health services.

Categories of capital requiring further clarification for the purpose of RHD cost sharing include:

- Information technology
- Residential care and assisted living
- Public private partnerships
- Multi-purpose facilities
- Other provincially funded services
- Regional referral centres
- Classification of capital
- Publicly funded equipment for fee for service physicians

3.1. Information technology

- The modern health system relies heavily on information technology: MRI, data transfer to improve rural access to specialists, BC Telehealth Program and increasingly sophisticated administrative systems for such things as financial management, scheduling and procurement.
- Information technology has not historically been considered capital and has been funded by the Province (Although RHD had been cost-sharing when IT was part of a larger facility project).
- There is a range of support among RHDs on the issue of cost sharing on information technology projects. Some are very supportive while others see this as potential "downloading" of a provincial responsibility.
- RHDs are generally more supportive of contributing to the capital costs associated with clinical information technology systems and less supportive of contributing to administrative systems.
- Some RHDs indicated a need for provincial standards for information technology to ensure compatibility within and between Health Authorities. There appears to be a low level of understanding of IT issues and priorities, including its role in the delivery of health services, which has resulted in a general disinterest in funding such projects.

3.2. Residential Care and Assisted Living

- Consistent with modern delivery of health services. Some RHDs contribute only to the acute care portion of these facilities while others make broader contributions.
- Varying levels of opportunity for Public Private Partnerships.
- In the future, residential long-term care facilities will be brought under the *Community Care and Assisted Living Act* which remove them from the RHD funding model. If RHDs are to continue to contribute to the capital costs associated with these facilities, the statutes and/or regulations will have to be coordinated to allow this.

3.3. Public Private Partnerships (P3s)

- The Ministry of Health Services requires Health Authorities to explore the option of a P3 for any new facility or major project.
- The likelihood of finding a private sector partner varies depending on the community in question. Remote and/or rural communities generally do not expect to be pursuing P3s.
- Given that the Health Authority will probably not own the asset, the nature of the RHD contribution could not technically be considered capital. In some cases it may be considered an operating subsidy.
- Each P3 will be unique. Therefore any guidelines established to govern RHD participation will have to provide sufficient flexibility to meet local needs.
- There is considerable uncertainty as to what form the RHD contribution might take, even in the most advanced case - Abbotsford Hospital and Cancer Centre (AHCC).

3.4. Multipurpose facilities

- Multipurpose facilities are consistent with current health practices and reflect the demand for integrated health care. They allow the Health Authority to use the excess capacity of existing acute care facilities for provincially funded community services.
- Some RHDs have successfully negotiated a blended rate contribution to reflect the co-located functions.
- Flexibility is viewed as a benefit in these situations, although some communities would prefer a formal process and certainty with respect to their responsibility to contribute to such facilities.

3.5. Other Provincially Funded Services

- Should facilities that have traditionally been provincially funded, such as mental health and other community services, be eligible for cost sharing? If so, at what rate?
- Some RHDs have indicated a willingness to discuss this and others have indicated clear opposition to increasing the “basket” of projects that they should be expected to cost share.

3.6. Regional Referral Centres

- In some Health Authorities, particularly in the north, patient referral patterns are not consistent with the location of regional facilities. This often creates disconnects between the Health Authority and particular RHDs in terms of establishing capital priorities.
- Some RHDs have negotiated cross-boundary cost sharing arrangements for facilities or equipment that benefit residents of more than one RHD. This has been done with varying degrees of success (satisfaction to participants) and without any guidance from the Province or the Health Authority.
- This was identified as an issue by a small number of RHDs but is particular concern in the Northern Health Authority, where residents in the northeast typically go Alberta to receive services and residents in the northwest would usually go to Vancouver. Prince George, although designated a regional centre is not easily accessible to many northern residents.
- Some RHDs feel that the Province should fund 100% of the capital costs associated with regional referral centers.

3.7. Classification of Capital

- The Province has reduced the number of capital:
  - Capital Improvement Projects/Information Technology and Equipment > $100,000
  - Capital Improvement Projects/Information Technology and Equipment < $100,000
  - Major Projects
- Some RHDs allocate a dollar amount for expenditures under $100,000, while others review detailed lists and authorize payment on a project by project basis. This is difficult for the Health Authorities and is not seen to be a cost-effective activity.
- Questions were raised with respect to the dollar amount thresholds.

3.8. Equipment for fee for service physicians

- Some communities have contributed funds for the purchase of publicly funded equipment located in the offices of private fee for service physicians.
- What is the nature of ownership of these assets?

4. PROCESS ISSUES

- Health Authorities are responsible for the assessment of program and capital needs and for developing strategic plans to address these needs. In executing this duty Health Authorities allocate health resources to ensure reasonable access to care for all residents of the province.
- Capital amortization and interest no longer a free good. This means that the funds required for debt servicing must come out of the operating budgets of the Health Authorities.
- RHDs have varying degrees of input into the capital decisions of the Health Authorities ranging from full participation in planning committees to rubber-stamp approval of HA plans and financial support.
- Some RHDs conduct an item-by-item review of proposed capital expenditures and examine invoices before approving payment.
- Some RHDs approve an annual capital grant and rely on quarterly reports from the HA and post-audit review to ensure accountability for funds spent.
- There is little consistency of process between Health Authorities. In some areas, RHDs have no role in establishing local priorities.
- There is no provincial policy for dealing with charitable donations of equipment not received through a hospital foundation.

4.1. Role of the RHD

- The consolidation of Health Authorities has had an impact on the role of RHDs. Further clarification of roles and responsibilities is required to complete the transition.
- Historically RHDs have played a more significant role in the planning process through involvement in Community Health Councils and Hospital Boards. There is significant divergence regarding the appropriate level of involvement for RHDs in establishing capital priorities.
- There is a wide range in contribution levels between RHDs as measured by comparing tax rates established to fund health capital. Some RHDs are servicing a significant amount of outstanding debt incurred for this purpose.
- Some RHDs feel responsible for representing community interests in capital planning process. In fact, some RHDs believe that without this ability to lobby the Health Authority, their communities would receive no health services whatsoever.
- Some RHDs see health care facilities as drivers of economic development. This is not consistent with the Health Authority's mandate to provide reasonable access to care.
- Some Health Authorities involve RHDs effectively in the capital planning process, while others believe that their facilities staff advocate on behalf of the community. There is no standard provincial process, which has led to divergent expectations.
- With rare exception, it is not evident that RHDs have staff with the technical capacity to evaluate the capital decisions and priorities established by the Heath Authorities.

- Several RHDs are represented on Project Building Committees and others have indicated a desire for such representation. Not all Heath Authorities are supportive of this type of involvement.

4.2. Communication

- Communication between Health Authorities and RHD has changed significantly since Health Authorities were consolidated. Most RHDs perceive this change to be negative, although many acknowledge that the Health Authorities are still in the process of establishing new systems and procedures for communication.
- Communication between Health Authorities and RHDs appears poor in most areas of the Province although some Health Authorities are clearly doing a better job than others.
- Some RHDs were unhappy that Health Authority meetings occur *in camera*.
- Many RHDs do not feel that they are sufficiently involved in the capital planning process or that they receive sufficient information from the Health Authority.
- The size of the Health Authorities is seen by many RHDs as a barrier to understanding and serving the specific needs of communities.
- Some Health Authorities have regular meetings and reporting procedures to facilitate information sharing with RHDs, while others do not. There is significant variation in the extent of disclosure practiced by Health Authorities.
- The Health Authorities provides information concerning capital plans and service plans on their web sites. RHDs making inquiries of Health Authorities are often directed to on-line information.
- There are no provincial standards or guidelines with regard to Health Authority-RHD communication. However, Memoranda of Understanding (MOU) have been initiated in each of the five Health Authorities.
- In general, the purpose of the MOUs has been to establish principles of good behaviour rather than deal with specific capital issues. To date none have been signed-off by all affected participants.
- Standardization of process was identified as a priority by a number of stakeholders.

4.3. Long-Term Capital Planning

- Issues related to timing of information and overlapping year-ends. Staggered year-ends result in unspent amounts being carried forward to the RHDs next fiscal year.
- Lack of long-term plans has been a significant problem. The Ministry will require Health Authorities to have a three-year capital plan in place by this fall. A process is required to ensure that these plans are communicated with the RHDs to allow them to plan for the longer term.

- Significant under-investment in capital throughout the province over the past 10-15 years and a lack of maintenance in some areas means that some Health Authorities have adopted "urgent priorities" that must be addressed as soon as possible.
- Three-year plans may not be sufficient to meet the planning needs of the RHDs. However, the Health Authorities may be reluctant to share planning information with the public that may be perceived as financial "commitments".
- The long-term plan must provide sufficient certainty for the RHDs to forecast local tax rates and to establish cash reserves for larger projects while at the same time being flexible enough to address changes in Health Authority capital priorities that may arise from time to time.

5. STRUCTURAL ISSUES

5.1. Project Scope

The solution to the capital cost sharing issues identified by this review may occur somewhere along a continuum of options. However, a number of potential solutions (representing the extreme ends of the continuum) have been specifically excluded by the Terms of Reference for this project. These include:

- Elimination of RHDs
- Locally elected representation on Health Authority boards

Despite being out of scope for this project, all of the Health Authorities and approximately 30% of the Hospital Districts indicated a desire for the RHDs to be eliminated. The reasons given by RHDs for this preference were that the current capital planning process did not provide sufficient opportunity for the RHDs to participate in capital decisions and that RHDs did not have the technical capacity to evaluate options and provide meaningful input.

The latter issue is amplified by the fact that the Ministry of Health Services no longer prioritizes capital projects. Many Health Authorities feel that the relative financial contribution of the RHDs is too small to warrant the administrative effort required to obtain funds.

5.2. Structural Issues

Several *ad hoc* organizational issues were identified during consultation. These issues may require the specific attention of the Ministry; however, each issue is unique and does not have a significant impact on the recommended cost-sharing model.

5.2.1. Communities not represented by RHDs

- Due to provisions in the Greater Vancouver Transportation Act, the Greater Vancouver Regional District no longer has RHDs, although the two affected Health Authorities (Vancouver Coastal and Fraser) include RHDs outside the GVRD.
- The GVRD represents almost half the population of the province.

Vancouver Coastal Health Authority

- There are four RHDs in the Vancouver Coastal Health Authority including:
  - Powell River RHD
  - Central Coast RHD

  - Sea to Sky RHD
  - Sunshine Coast
- Many of the communities represented by these RHDs are remote, rural and less affluent. Communication between these RHDs and the Health Authority is inadequate, possibly due to the cultural differences between the RHDs and the Vancouver Coastal Health Authority or an inability of some of the RHDs to participate in the capital process.

Fraser Health Authority

- The Fraser Health Authority has only one RHD – the Fraser Valley RHD. This is a unique situation that may require a unique solution.
- The search for a solution is tempered by the fact that Fraser Valley RHD has made a commitment to contribute $71 million to the AHCC, which is being acquired through a P3.

5.2.2. RHDs with no tax base

- Some RHDs, such as Central Coast, do not have a sufficient tax base to contribute to capital projects. This is due to low property values and a large portion of the population that is on-reserve and therefore exempt from local government property taxation.
- Regional economic disparity is a reality in the province, and this process will not change this. Restructuring of RHDs would not change the fact that some communities do not have access to sufficient resources to participate in capital funding and may exacerbate the situation by requiring some communities to "subsidize" health capital in other communities.
- Health Authorities are responsible for providing health services regardless of the community's capacity to contribute to capital.
- What is the extent to which non-partnered projects detract potential project capital away from other communities in the Health Authority? Does this represent a subsidy?
- In practice RHD participation in capital projects is voluntary and dependent on the fiscal capacity of the community

5.2.3. RHDs in more than one Health Authority

- Cariboo-Chilcotin RHD straddles the boundaries of two Health Authorities (Northern HA and the Interior HA). This may create some administrative inefficiency and is inconsistent with the rest of the province.
- The RHD has not requested a change in this arrangement, and neither Health Authority raised it as an issue.
- 40% of the CCRHD tax base is in Quesnel may create potential problem if the RHD were to be split.

5.2.4. RHDs with large on-reserve First Nations populations

- In the past the federal government transferred funds directly to RHDs to cover the portion of their capital contribution that related to on-reserve First Nations Populations using a predetermined formula.
- More recently this amount has been included in the Health and Social Transfer provided to Province by federal government.
- This is seen as a loss of funding created a local financial burden by some RHDs, particularly those in the northwest of the province.
- The portion of this transfer that relates to health capital is assumed to flow through the Ministry of Health Services into the Health Authority capital budgets to cover capital costs in RHDs with large on-reserve populations; however, it would be extremely difficult to actually follow the flow of dollars that relate specifically to capital.

5.3. Other Jurisdictions

A cursory review of practices in other provinces illustrated significant variety in approach with regard to funding health capital. Saskatchewan's system of capital funding is most similar to British Columbia, with a 65/35 cost share between the Province and municipal districts and 100% government funding for regional projects. Alberta, on the other hand, funds health capital entirely out of the provincial budget. In the Province of Ontario there is increased pressure being put on Municipalities by the Hospital Association. However, comparisons are difficult in that there are many unique systems of health delivery and municipal governance throughout the provinces. This diversity suggests that there is no "best practice" and an approach unique to British Columbia will be required

6. EVALUATION CRITERIA

These issues will guide the development of an enhanced capital cost sharing model for the Health Authorities and RHDs.

Based on the issues that were identified with stakeholders a number of guiding principles were identified. These include:

- Taxation and accountability – RHDs levy local property taxes for the purpose of contributing to the capital cost of health care facilities. This makes them accountable to their constituents to ensure that money is spent responsibly.
- Regional services – local contributions must benefit the local community.
- Clear definition of capital – must reflect modern delivery of health services.
- Participation of RHDs - clarity and certainty is required to facilitate long-term capital planning and multi-year budgeting for both the Health Authority and the RHD.
- Allocation of health services - if local governments are expected to contribute to capital projects they must have a role in determining how those resources are allocated.

The proposed solution must also achieve a number of strategic goals, including:

- Process simplification and standardization
- Definition of capital
- Governance model – clearly established decision making authority.
- Distinction between projects vs. acquisitions
- Project distribution across the Health Authority

The next stage of consultation will involve representatives of Health Authorities, RHDs, the Ministry and the UBCM health committee through a series of focus groups. The purpose of these meetings will be to look at some options for a new capital cost-sharing model and to apply these evaluation criteria in order to test and refine the options put forward.