CONVENTION SESSION BACKGROUNDER

REGIONAL HOSPITAL DISTRICTS & THE 2003 COST SHARING REVIEW

September 2007

TABLE OF CONTENTS

INTRODUCTION

Recent UBCM activities on the topic of local government relations with the Health Authorities have focused on Regional Hospital Districts (RHDs).

The concerns of the RHDs have been considered in the context of the 2003 Regional Hospital District Cost Sharing Review recommendations. Resolution of these concerns is sought through further discussions with the Ministry of Health, the Health Authorities and the Regional Hospital Districts.

This Status Report serves as preliminary analysis and background for these discussions. The key question we are asking is: "Have the report's recommendations been incorporated into practice from the RHDs' perspective?" It is not meant to be a comprehensive review, but rather to offer material for further discussion and a starting point for resolving the priority issues our members have identified.

RECENT ACTIVITIES

Four years have passed since the Cost Sharing Review was presented to the Health Authorities and Regional Hospital Districts. UBCM has continued to hear concerns from our members around their relations with the Health Authorities. In 2006, members, Health Authorities and Regional Hospital Districts participated in a UBCM survey on their communication and consultation practices. A session at the 2006 Convention was held to discuss the outcomes of the survey. A resolution calling for a public forum to review the health authority framework was referred to the Healthy Communities Committee.

UBCM convened a meeting of Regional Hospital District Chairs on August 2, 2007 to discuss common concerns. 15 of 23 RHDs participated. The discussion highlighted a number of priority issues. It also considered the progress that has been made on implementing the recommendations of the 2003 Cost Sharing Review.

Regional Hospital District representatives were asked to comment on their experience regarding capital funding, accountability and process issues; issues that have continued to be raised by UBCM members since Health Authority restructuring in 2001. It was agreed that many of the current concerns were consistent with those presented during the consultations for the 2003 Cost Sharing Review. New issues were also noted.

In the interest of establishing key priorities, three issues were selected. These are: Long Term Planning/Funding, the Funding Formulas (including First Nations funding), and Budget Cycle/Cash Management. These priorities are well aligned with the four main themes set out in the 2003 Review: accountability, definition of capital, process issues and unique structural issues.

In preparation for further discussions, this report offers a preliminary review of the progress made on the recommendations of the 2003 Review. The original recommendations are listed, along with indications of their status, based on comments received from the Regional Hospital District Chairs at the August meeting.

BACKGROUND

The 2003 Regional Hospital District Cost Sharing Review was prepared following a series of stakeholder consultations. Issues of concern for the stakeholders were focused around the four main themes of accountability, definition of capital, process issues and unique structural issues. These themes are briefly described below, based on the original report.

ACCOUNTABILITY ISSUES

As a taxing body, the RHDs must have sufficient input into capital decisions to meet reasonable tests of accountability to their ratepayers.

DEFINITION OF CAPITAL

Changes in health care and service delivery since the *Hospital District Act* was established means that the original definition of capital (hospitals and diagnostic equipment) may no longer be appropriate. As a result, there has been no consistent agreement on what items should be eligible for RHD cost sharing and actual contributions made by RHDs vary considerably.

New facilities and major projects are required by the Province to be considered for Private Public Partnership (P3) funding. Any RHD contributions to the asset must be clearly defined.

PROCESS ISSUES

A lack of standardized processes relating to communication between Health Authorities and RHDs led to some issues of mistrust.

The coordination of budget cycles also created difficulties. Health Authorities have a fiscal year-end of March 31 while RHDs have a December 31 year-end.

STRUCTURAL ISSUES

The stakeholders in the 2003 review identified a variety of structural issues. They were generally unique to one area and did not affect the recommended cost-sharing model.

The issues included: areas not represented by RHDs; RHDs with no tax base; RHDs in more than one Health Authority; Patient referral patterns; Cross-boundary cost sharing and RHDs with large on-reserve First Nations populations.

GUIDING PRINCIPLES

The 2003 review used the following principles to design a cost-sharing model that addressed the issues of the stakeholders:

- Taxation and Accountability
- Consistent with Modern Health Services
- RHD Contribution Limitations
- Contributions must benefit the Local Community

RECOMMENDATIONS

ACCOUNTABILITY ISSUES

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

Indicator	20 of the 23 Regional Hospital Districts have signed Memorandum of Understanding Agreements with their Health Authorities. Some also have independent protocol agreements. Relations and communications have been improving in most cases.

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.

Indicator	RHDs have been approached for funds and the availability of their 40% has been a deal-breaker. May be problematic for smaller communities to provide 40% but community still requires the facilities.

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

Indicator	Several RHDs cited examples of being asked to contribute 100% towards locally identified priorities.

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

Indicator	Plans for new capital projects need to be accompanied by a commitment to staff new facilities.

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

Indicator	Problems encountered when project additions over time increase costs, and the 40% share increases as a result.

DEFINITION OF CAPITAL

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.

Indicator

RHDs are concerned with clear accountability in P3 projects.

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

Indicator

Require a better definition of minor capital items to ensure that RHDs are not funding operational costs.

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.

Indicator

RHDs are concerned that they are being asked to fund a broader range of projects.

PROCESS ISSUES

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.

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

Indicator

Numerous RHDs were concerned that the Health Authorities did not have funding commitments from the Ministry beyond one year and therefore operated on one year planning timelines. Capital planning process requires longer timelines.

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.

Indicator

Last minute funding requests from Health Authorities are difficult for RHDs to deal with.

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.

Indicator

Some RHDs still feel that they are approached with already decided plans and budgets – simply asked to make their contribution rather than provide local input into planning processes.

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

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

Indicator

RHDs still feel that the coordination of different budget cycles creates difficulties. Cash management is also an issue where the RHD has committed to funding a project and the HA doesn't request the funds in a timely manner.

STRUCTURAL ISSUES

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

Indicator

The *Hospital District Act* [RSBC 1996] Chapter 202 still contains references to "*hospitals and hospital facilities*".

CONCLUSION

The 2003 Regional Hospital District Cost Sharing Review suggested a preliminary implementation strategy for the above recommendations. It suggested that the process of moving to 5 year rolling capital plans begin in the fall of 2003. The Ministry would need to pursue the recommended legislative amendments to the Hospital District Act and it was suggested that the Ministry should offer facilitation support for the new model.

Recognizing that time would be required to fully implement the new model, the report also recommended that:

> 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.

The original review was distributed to the Regional Hospital Districts and Health Authorities in September of 2003. Four years have now passed. The assembled Regional Hospital District Chairs at the August 2, 2007 meeting agreed that it is time to evaluate the progress that has been made.

It is recommended that the Ministry of Health undertake a joint Ministry, Health Authority and Regional Hospital District review of the progress in implementing the recommendations of the 2003 Regional Hospital District Cost Sharing Review.

Further discussion and consideration of the indicators and recommendation offered here are anticipated for the Relations with Health Authorities session at the 2007 UBCM Convention.

PROGRESS EVALUATION: 2003 REGIONAL HOSPITAL DISTRICT COST SHARING REVIEW

		Worse	Same	Better
Problems Identified	Opportunities for local input			
	No consistent agreement on items eligible for cost-sharing			
	Clarity around P3 projects			
	Lack of standardized communication			
	Coordination of budget cycles			
	Affordability of 40%			
	Cross-boundary cost sharing			
	RHDs with large on-reserve First Nations populations			

		Not Adopted	In Some Cases	Adopted
Recommendation for Action	HA to develop and maintain effective working relations			
	RHDs not expected to contribute more than 40%			
	Budgetary overruns or delays are the responsibility of the HA			
	Simplified categories of capital	?	?	?
	Clear accounting definitions for P3 projects			
	RHDs to allocate a lump sum contribution to minor capital items			
	RHDs should not see an increase in overall ratio of contributions			
	Implementation of new processes to start in fall of 2003	?	?	?
	HAs to move towards 5 year rolling capital plan and standardized communication processes	?	?	?
	Joint planning meetings to be held before budgets finalized by either RHD or HA			
	Recommended legislative amendments			

Attachment 1

Regional Hospital District Meeting
Meeting Summary
August 2, 2007
10:30 am – 2:30 pm
Viscount Room, Delta Vancouver Airport

Meeting Participants:

Mike Phelan, Manager of Budgets	Fraser Valley RHD
George Ferguson, Chair	Fraser Valley RHD
Don Zurowski, Chair	Fraser-Fort George RHD
Sonny Beck, Chair	Stuart Nechako RHD
Hans Berndorff, Financial Administrator	Stuart Nechako RHD
Fred Banham, CAO	Peace River RHD
Karen Goodings, Chair	Peace River RHD
Al Richmond, Chair	Cariboo Chilcotin RHD
Janis Bell, CAO	Cariboo Chilcotin RHD
Colin Palmer, Chair	Powell River RHD
Frances Ladret, Administrator	Powell River RHD
Bob Lapham, General Manager, Planning & Protective Services	Capital Region District
Robyn Loukes, Hospital Accountant	Capital Region District
Marilyn Davies, Vice-Chair	North West RHD
Joan Rysavy, Administrator	North West RHD
Joe Mackenzie, Treasurer	Mount Waddington RHD
W.J. (Jack) Peake, Chair	Cowichan Valley RHD
Glenn Wong, Chair	Alberni Clayoquot RD
Barry Janyk, Chair	Sunshine Coast RHD
Joan Merrick, Treasurer	Sunshine Coast RHD
Lawrence Chernoff, Chair	West Kootenay Boundary
John MacLean, CAO	West Kootenay Boundary RHD
Paul Edgington, CAO	Sea to Sky/ SL RHD
Susan Gimse, Chair	Sea to Sky RHD
Walter Despot, Chair	Okanagan-Similkameen RHD
Jim Zaffino, General Manager Finance	RD Okanagan-Similkameen

Staff:

Richard Taylor, Executive Director, Union of BC Municipalities
Lesley Arsenault, Policy Analyst, Union of BC Municipalities

PURPOSE OF THE MEETING

Chair Susie Gimse outlined the purpose of the meeting as an opportunity to discuss concerns regarding relations between Regional Hospital Districts and Health Authorities and to get consensus on the issues of concern before discussions with the Minister and Health Authorities this fall.

Particular issues were highlighted such as:
- lack of capital funding,
- lack of long term planning process for both HA's and RHD's,
- a level of taxation that is reasonable for local governments, and
- prioritization of capital projects.

BACKGROUND

Chair Gimse outlined the related UBCM activities that have occurred, including the survey, the Convention Session and Health Authority presentation, all done in 2006. UBCM was also involved in the 2003 review of the Regional Hospital District Capital Cost Review performed for the Ministry of Health Services.

The Ministry of Health Services Regional Hospital District Cost Sharing Review in 2003 was conducted to ensure an appropriate role for RHDs in capital planning processes and to suggest the changes necessary to legislation and processes to implement that role. The report made recommendations to regularize the process of interaction between RHDs and HAs in terms of the capital planning process and communications in general.

Particular recommendations from the Review related to this meeting include:

- the onus is on the Health Authorities to develop and maintain effective working relationships with the RHDs within their regions, as RHD contributions are voluntary;
- a new process for capital planning was recommended to begin in the fall of 2003 and lead to 5 year rolling capital plan for health authorities;
- the report also recommended clarification of what is considered "capital" so as to create flexibility for what types of capital can be cost shared, which was not meant to increase RHDs contributions.

ROUNDTABLE

The Chair opened the floor for a roundtable discussion on the issues of concern.

Okanagan Similkameen
No major problems with IHA were noted. However, availability of proposed budgets in time for the RHD to incorporate has been a concern. Suggested that alignment of the HA budget cycle to the RHD cycle would be beneficial.

Fraser Valley
Concerned over requests for funding beyond 40%. Situation has occurred where the FVRHD wanted to maintain a facility (Mission hospital) that Fraser Health didn't want, told to fund capital at 100%.

Fraser- Fort George
Capital related funding and budget timelines were cited as creating difficulties in planning. Noted that relationship with HA and communications have been improving, including recognition from NHA for shared funding. NHA and Ministry seem averse to taking on debt while the RHD is willing to make funding commitments if combined with long term operating agreements. Ministry not as cooperative when celebrating new projects to recognize the local share.

Stuart Nechako

Community with very small tax base and large First Nation population, limited industry creates great difficulties in funding health capital projects. Cited problems of being able to contribute 40%. Concerned with lack of flow through for federal funding of First Nation health. Also concerned with planning process where capital projects are pre-approved by HA before coming to RHD. Need examination of the use levels of health facilities by First Nations.

Peace River
Also concerned with First Nation health funding. Budget timelines. Have an agreement in place with Northern Health that if their requests come after RHD budget is done, they won't expect any funding. Also have concerns regarding P3 projects. Concerned that the Health Authority sometimes has to align with provincial goals instead of local goals. Very concerned with facilities for mental health patients. Patients relocated due to closing of Riverview but the Province has not created a viable replacement. Has created dangerous situations for both mental health and other patients, staff, etc.

Cariboo Chilcotin
Deal with Northern Health and Interior Health and the relations are getting better. Have developed MOUs and protocols. Concerned with lack of long term planning processes from the Province, which limits the ability of HAs to plan. Need to see more discussions with HAs before the budgets are committed. Have developed an agreement with First Nations to provide better rural services including ambulance.

Powell River
Have dealt with very poor communications, including poor public relations. Have MOU now with VCHA and work cooperatively with other RHDs. Concerned over the broader range of projects RHD are being asked to contribute to. Concerned over requests to provide more funding, need to "attract" people to do the projects, so need more funding. See the lack of commitment on capital planning from the Ministry as a problem. Also concerned with what appears to be creeping download; RHD is not responsible for youth programs, Crystal Meth, mental health, etc.

Capital Region
Becoming involved in complex care, need policies to address new areas of health services and the RHD role and level of funding. Due to large numbers of capital projects, may need to seek trade offs with Province on infrastructure funding. Also concerned with P3 financial accountability.

North West
Concerned with lack of vision from Northern Health, not responding to local concerns. Seem to be only concerned with replacing what already exists. Do not feel an ability to influence capital planning as they are approached with already decided plans. Also see the results of a huge First Nations population. Have been expected to pay 100% for locally identified priorities (Masset hospital). Need to be included in pre-budget and budget meetings with HA and Ministry.

Mount Waddington

Availability of 40% funding was seen as a deal breaker with VIHA, despite recommendations from Cost Sharing Review. Concerned with affordability of 60/40 cost sharing. Funding continuity from Province and HAs is required. Suggested that 40% of funding should get 40% of decision-making.

Cowichan Valley
The 3 existing funding formulas for health care are not seen as beneficial. Need ability to have input into local health delivery. They are handed down budgets and not involved in decision making. Concerned also with First Nation funding. Need long term planning, 5 to 10 years is not long term, not to mention 1 year planning.

Alberni-Clayoquot
Need communication to go through many bureaucratic levels, all the way down through staff. First Nations health funding is also a concern. There seems to be an expansion of the types of projects for which the 60/40 sharing is requested. Experienced an erosion of services in a new facility, need to ensure commitment of operating funds for new facilities to ensure staff for it.

Sunshine Coast
Good relations now with VCHA with the development of a MOU. Ministry needs to create decisive planning direction among their staff. Also need a better definition of minor, under $20,000, capital to ensure that RHD is not funding operational costs.

West Kootenay Boundary
Micromanagement by the Ministry remains a concern. Lack of long term planning. Cash management is a concern where the RHD commits funds but HA doesn't act quickly and comes back for the money much later. Also concerned that there is a need to commit to staffing new facilities. Recognizes that there is a push to contribute to tertiary IHA facilities in neighbouring RHDs and wants to be involved in any discussions around cost-sharing.

Sea to Sky
Better relationship with VCHA and between three RHDs. Problems seem to arise when the HA finds last minute funds from the Province and expects 40% from RHD. Flaws in capital planning process including constant additions to project costs which increase 40% share. Pressure to centralize facilities but there needs to be rural services. Concerned with provincial land use deals which add/change populations that will require health services. Would like to see more respect for elected official input. There needs to be recognition that blanket funding formulas don't work well given the geography of the province.

In a second roundtable discussion, the Participants highlighted the following achievements as successes:

Cariboo Chilcotin
Created a task force with First Nations groups and Interior Health to discuss better health services in rural areas. Signed an MOU on communication and accountability processes for projects.

Peace River
The NCMA organized Northern Caucus meetings have been very beneficial. Have an MOU with Northern Health, which is beneficial as it creates commitment.

Powell River
Established a twice yearly liaison committee and an MOU on capital planning. Good cooperation with Sea to Sky and now are seeing improving rural services. Seeing great advances in rural care through innovations like telehealth, teleradiology, etc where connections are enhanced with specialists in major centres.

North West
Meeting held at NCMA with others in area association to discuss issues. Also, beginning to have input into joint Northern Health and RHD conferences. Recently held a Board to Board meeting with Northern Health. The Health Bus project which travels to Prince George and Vancouver and a number of new capital projects.

Sunshine Coast
COO Hotline with the Health Authority – beneficial direct relationship between Chair and COO.
Aging population in the area requires new techniques – requiring commitments to social amenities from developers to contribute to the community.

Cowichan Valley
Telehealth and Teleradiology are helping. Discharge planning for patients sent to Vancouver, good work with YVR. Partnering with First Nations and federal government to work on rural nursing stations.

Sea to Sky
Created a governance liaison committee that includes local government, RHD, HA and First Nations, and hospital foundations. This committee has helped to change HA priorities. Also established a protocol agreement. Beginning to see recognition of the RHD as a level of government.

Fraser-Fort George
Care North Strategy from Northern Health is a good innovation. Group Care. Recruitment success in rural areas. Protocol agreement between NH and RHD is helping build trust. Work occurring between Ministry of Education and Ministry of Finance to educate health professionals in rural areas.

Fraser Valley
Hospital Foundation fundraising for the Abbottsford Cancer Centre to provide the most up to date equipment at the time the hospital opens has raised more than $75 million.

DEVELOP CONSENSUS ON KEY ISSUES

Based upon the Roundtable Discussion, six themes were developed as priority issues.

1. Long Term Planning / Funding
    a. Include Ministry/HAs/RHDs in meetings

   b. Consideration of local priorities
   c. Operating funds to staff new capital projects

2. Funding Formula (what and how much)
   a. Scope of capital projects
   b. "if you want it, pay for it" (100%)
   c. contribution to other regions
   d. < 40% funding for small RHDs
   e. one size doesn't fit all
   f. scope reductions (when cost overruns occur)

3. First Nations and Federal Funding
   a. Provincial cooperation
   b. Transparency

4. Budget Cycle and Cash Management
   a. Delays
   b. Surprises
   c. Different year ends
   d. Double billing
   e. Multi-year projections

5. Decisions made before RHD approvals

6. Ministry Communications
   a. Joint announcements

Further discussions identified that Item 3 could be treated as a subset of Item 2, Funding Formula.

The Group prioritized the items with Items 1, 2 and 4 identified as top concerns. These items will be taken forward for discussion with the Ministry and Health Authorities in the September meeting.

TAKING THE ISSUES FORWARD

Richard Taylor outlined an approach to proceed with taking the identified priority issues forward to the Ministry.

Staff will develop a report based upon the recommendations of the 2003 Regional Hospital District Capital Cost Sharing Review. The issues identified in this meeting will be related to the recommendations contained in the Review. The report will serve as an update to the 2003 Review and discuss how the Review's recommendations have or have not been incorporated into practice from the RHD perspective. The RHDs would be recommending to the Minister to a joint Ministry, RHD and HA review of the progress in implementing the 2003 recommendations and what needs to be done if the recommended directions have not been achieved.

The draft report will be circulated to the participants of this meeting for comments prior to the meeting with the Ministry and Health Authorities.

CONCLUSION

The Chair closed the meeting at 2:30 pm with thanks to the participants for attending and sharing their concerns.