Governance and Accountability

*Governance and Accountability* within the health care system was raised time and again by participants in the Conversation on Health. Participants are concerned that the governance structure for the health care system undermines its ability to undertake proper long-term planning. They also worry that the structure is too fragmented to ensure effective delivery of health care services, and that there are no consistent performance management systems to analyze the success of that delivery. Some suggest inefficient health authority administration contributes to the fragmentation of the system. Here is a selection of what British Columbians had to say on the subject of *Governance and Accountability*.

Health Care Planning

Participants uniformly seek improvements in how we plan around health care. Currently, participants believe planning is fragmented between health authorities and the Ministry of Health. They argue there is no overarching plan forming the basis or foundation for health care delivery across all health authorities. Furthermore, the budget, information technology and health human resource plans appear to be separated from any consistent health care delivery or system plan. Participants are also concerned with what they perceive to be undue political interference in the planning process, which will lead to short-term goal setting at the expense of long-term improvements. Similarly, British Columbians are worried about the influence of lobby groups, industry, unions and professional associations on planning and decision-making. In the absence of a clear and consistent planning cycle and approach, participants believe that we will be unable to develop a clear health plan that will lead to systemic improvements in the delivery of care.

Many participants suggested that there be a centralized planning function, which would set goals and measures for the whole system. The central function would develop long-term plans and would also be responsible for sharing those plans with the public. While many feel there should be a centralized long-term health system plan, they suggest that in order to be effective it must be integrated with other plans across the Government of British Columbia affecting the health of our citizens. Plans associated with housing, income assistance, and children must all speak to one another and be accountable to similar population health measures and outcomes. Participants understand that this is a challenge for government, but emphasize it must be overcome if we are to truly contribute to the health of our population.
British Columbians believe that a strong and disciplined planning cycle will yield improvements in the overall management of the health care system. This cycle must include the ability to evaluate progress over the course of the year and make improvements and adjustments. While many participants were concerned with adopting business practices into the health care sector, most wanted to see at least some aspects of business models incorporated, including accountability structures, process improvement, results measurement and the adoption of best practices.

Transparency is a big part of any successful planning cycle, and participants want to see more openness around health care planning, budget management and reporting. A number of participants advocated for an objective third party oversight of the health system. They suggested common report cards, organizational reviews, results measurement, and audits as ways of more effectively measuring the success of the health care delivery system and reporting on that success publicly.

Planning needs to be longer term and better coordinated, based on cost effective outcomes and driving towards change. The vision needs to be structured so it can be operationalized and it needs to be properly financed. To build this plan and the vision, we need to first think about the kind of health care system we need, then information technology and infrastructure become a means to that end, and flexibility can be built into the system.

- Health Authority Board Session, Vancouver

Governance Structures

There was some debate about the existing roles and responsibilities within health care delivery and whether or not they serve the needs of British Columbians. In particular, the roles and responsibilities of health authorities came under intense scrutiny. For some, the shift to larger health authorities away from smaller, locally elected boards marked a dramatic and negative shift away from community-based responsibility. For others, this same shift was seen as an improvement over a more fragmented system of delivery which was unable to cope with system-wide changes and needs. Regardless of their perspective, most participants believe that the governance and accountability structures need to be clarified and operationalized. For some, there is too much interference from the Ministry of Health in operational matters which should be within the scope of the health authority’s responsibilities. These participants want to see the Ministry of Health set broad strategies, policies and targets for outcomes, provide the tools and resources to do the job, then leave the health authorities to get it done.
Some participants raise the idea of creating a health Crown corporation structure. They argue that this would reduce political interference, increase overall responsibility, and create a clear legal governance framework. They suggest a Crown corporation model is able to more easily engage in long-term planning and would provide a provincial perspective to the health authorities, which would be treated as operating arms.

There was a debate among participants, particularly through the Online Dialogue, about the extent to which there should be a governance structure that is more national in scope. For some, a nationally run system would be expensive and unwieldy, and would lead to greater, not less, segmentation within the system. A number of participants raised the current constitutional structure which gives the provincial governments the authority to run health care. That being said, many participants believe that there is a national perspective which would ensure greater consistency in terms of the level of care without undermining the need for local and regional adaptation.

Many participants advocate for a return to more local democratic engagement in health care, whether through elected hospital boards or health authority board members. First Nations also believe that they need to be involved in management of health care delivery to ensure that the unique needs of their communities are understood and accommodated. Some participants suggest community health advisory bodies, which, they argue, already exist in some health authorities. Regardless of the means, many British Columbians believe that their input is important to ensuring that the system runs smoothly and is accountable to their requirements.

Accountability structures were raised as an important tool for maintaining the course over the long-term. Participants believe there needs to be guidance and accountability throughout the system, from the Ministry of Health through the health authority boards and administrative structures. There was no consensus on what this structure would look like, but many agree it needs to include holding individuals accountable for the successes and failures of the system and its programs. This also includes ensuring that adequate resources are provided to ensure the success of the programs.

There was also some debate about whether primary care should be the responsibility of health authorities. The question centred around whether moving primary care to health authorities (including physicians) would result in improved population health.
Regardless of which side of the argument participants landed on, most are looking for a governance system that encourages innovation, replicates best practices across the province, is transparent in its reporting and management processes, and has consistent measures and long-term goals. Consistency between health authorities in terms of measures and data is a key component of a successful health care system. Participants believe that these are the ingredients to ensure that the delivery of health care continues to improve and adapt to accommodate the changing needs of British Columbians.

*I think one of the hugest barriers in Canada to getting it right is the fact that we’re so fragmented that every province has their own system. [T]he Federal Government hands out money, and then the provinces hand out money, and then the health authorities hand out money. But nobody’s minding the gate. Nobody’s saying, ‘Okay, this money goes with this attached. You have to do this, this, and this or we’re not giving it to you.’ And that never happens… [I]t has got to start from the top and work down if we’re ever going to get together…*

- International Symposium, Vancouver

**Performance Management**

Participants generally perceive the current approach to performance management to be sub-standard. Insufficient attention to incentives, lack of clear measures or of measures that focus on outcomes, and lack of provincially available data, among others, are the reasons British Columbians think that the health care system needs a revitalized performance management system.

One issue that came up frequently was the lack of specific financial information related to health care costs. Specifically, participants want to know what the total costs are for any given procedure. They argue that, in the absence of this data, it is impossible to judge the efficiency of any approach, and therefore impossible to know which approach to adopt.

While many suggest that a culture of accountability needs to be driven in throughout the system, there is recognition that we also need to focus on data gathering that allows us to effectively measure the progress of the health care system. Measuring population health in the same way throughout all health authorities should be a priority. Participants believe reporting on those measures and being transparent in the actions to achieve the goals will increase accountability across the province. Like the planning cycle, we need to have a long-term perspective on the measurement and achievement of goals and objectives.
You can be either tight on the outcomes you’re going to achieve and free the system up to get to those outcomes, or you can be tight on the process that you ask people to follow to give you all the outcomes… One of the UK successes was they established some very, very rigorous targets for delivery and then … they put some money into the system and they said, 'You have to hit the target. Do what it takes to hit that target.' What we do here is … we have to have targets but often we don’t invest and put the resources in.

- International Symposium, Vancouver

Health Authority Administration

Many participants wrote in or discussed their individual views and perspectives of health authority administration. Their most common concern is that the boards fail to engage and listen to the members of the community. These same participants often call for a return to elected boards which are accountable at the community level. There was also a frequent request, particularly by northern and interior participants, to divide the larger health authority regions into smaller areas.

Another concern is the focus on financial objectives and achieving budget targets. To many participants, this is done at the expense of quality patient care. They advocate for the introduction of new measures for success for health authorities beyond budget management.

Administrative staff came under fire during the Conversation on Health. Participants cannot agree on whether boards and health authority executives need to have a background in business or the health profession. There is a concern about high salaries, large payouts to departing executives, too many executives and managers, and a lack of attention to health outcomes in favour of a strictly financial approach.
Conclusion

There is no consensus around how to or who should manage the health care system. Participants debated the governance structure, the extent of public involvement, the administration of health authorities and the performance management system. Through it all, there was agreement that there needs to be more disciplined attention on all of these aspects of the delivery of health care. Furthermore, participants uniformly believe that there needs to be a long-term integrated plan, along with some common way of measuring how the system is doing and whether it is meeting the needs of British Columbians. To the participants, focused attention on governance and accountability structures would help the health care delivery system meet the needs of the citizens of British Columbia today and into the future.

We have to have continuous annual evaluations and re-evaluations of what we are doing. We are not going to get it right the first time. We are going to have to continue to meander down that course to the end goal, but making sure that we go back to Canadians, go back to the one single payers that pay the bills and say, ‘this is how far we have gone, here are our successes but also here is our failures’ and let them know in transparent form, where we have gone and where we are going.

- Provincial Congress, Vancouver
Governance and Accountability

This chapter includes the following topics:

- **Health Care Planning**
- **Governance Structures**
- **Performance Management**
- **Health Authority Administration**

### Related Electronic Written Submissions

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<td><strong>Sunshine Coast Conversations on Health</strong></td>
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### Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including:
- Health Care Models
- Health Human Resources
- Training
- Access
- Morale
- Innovation and Efficiency
- Public Private Debate
- Health Care Spending
Health Care Planning

Comments and Concerns

Planning Terms, Cycles and Linkages
Planning Responsibilities and Accountability
Local and External Involvement in Planning

• Comments on planning terms, cycles and linkages:
  • Decisions are being made on ideological basis, not on quality of service and cost-effectiveness.
  • There is no priority-setting in communities regarding services or capital projects.
  • Politics needs to leave the health field. It seems that if you have effective lobbying, your problem or disease gets funding. This results in certain areas not getting addressed.
  • There is no provincial vision, plan, or accountability for rehabilitation.
  • It is difficult to plan, develop, implement and evaluate initiatives that are either piloted or run in an organization and are subject to operational variances or dependent on variable one time funding.
  • It is absurd that our provincial health authorities are provided with budgets that are not based upon concrete facts.
  • The Ministry previously committed to developing a directional plan for health care, but it still has not produced that plan. We had an entire Ministry of Health Planning that did not produce a health plan. You do not want a detailed plan that is inflexible, but you do want a directional planning exercise so that we know where we are headed and can empower all the various health authorities to head in a similar direction, but not to tell them what to do.
  • For the providers and distributors of medical device technologies, a major challenge is determining where their product release fits within the health authority region’s budgeting cycle. For example, if a new technology is released mid or even later in the year, regions do not have new funds and are required to reallocate resources to purchase the recommended medical device technologies.
  • The goals need to be focused on our biggest long-term concerns, not necessarily the concerns that, this month, have the greatest fear factor.
  • The provincial framework on end-of-life care has a statement that is absolutely glorious and is not translating into the health authorities. They give it to the health authorities as a guiding principle but the health authority has a choice as to
whether they take that on or not, or how much they do. There are a couple of planning tables around end-of-life care at the health authority level, but we have been planning \textit{ad nauseam}. We are no further ahead now than we were before, because there are no teeth in what the health authority is doing.

- Health policy needs multi-year strategies (not tied to the election cycle).
- In a health authority you look at finance, information technology and the whole spectrum and how it interrelates. Another way of putting it is taking a systems approach.
- If a shortage in health human resources is the number one risk to delivering health care in the future, why are we as an organization not talking about corporate accountability and a corporate approach?
- There should be a definite link between regional growth and health care planning.
- Health authorities are concerned that long-term health planning is complicated by the political reality of four-year terms of office. As a result, it is difficult to look forward past the four-year timeframe to make effective long-term plans.
- We have to have continuous annual evaluations and re-evaluations of what we are doing. We are not going to get it right the first time. We are going to have to continue to meander down that course to the end goal, making sure that we go back to Canadians, go back to those that pay the bills and let them know how far we have gone, what our successes are, and also what our failures are. We have to be transparent about where we have gone and where we are going.
- There is a need for a strategic plan that identifies the priorities across health authorities.
- The challenge is that we want to improve health outcomes. To do that, the government needs to take a much broader and more integrated look at what health programming is being done in different ministries.
- Planning is improving, but not enough and not quickly enough. Planning must be evidence-based, and political agendas should be set aside.
- We need plans that actually work.
- The British Columbia health care system has long operated under a so-called silo model. Under this approach, the health care system is divided into a series of discrete segments (for example, hospitals, health insurance, health protection, health promotion, mental health, drug programs, and so on). Planning, budgeting, administration, management and delivery activities generally are aligned to these individual program areas.
• **Comments on planning responsibilities and accountability:**

  • Hospitals and services for rural areas cannot be planned at a desk in Victoria. Planners must work in concert with doctors, nurses, municipal officers and residents before decisions are made.

  • There are so many professional and union groups successfully pressing their own agendas on the federal and provincial Ministers of Health. It is time that an office headed by an Auditor General for health practices be set up by the federal government, preferably with the support of the provincial governments.

  • There is a clear role for public policy advocacy by health authorities. Health authorities have a responsibility to advocate as they have the knowledge, research, expertise and the overall mandate for health that community groups and individual citizens lack. It is critical that advocacy be done in areas where it is clear that negative health outcomes will occur in the absence of a specific public policy initiative. Health authorities will need to have the courage to step forward on some controversial issues. Further, they have to be selective in the advocacy choices they make to maintain their legitimacy to speak out on issues outside the jurisdiction of health care. This is necessary because the strength of their messages may become weak if they are too diffuse in their priorities. Also, there is limited capacity for this work. Clear priorities include the importance of economic status. The strong connection between poverty and health means health authorities have a responsibility to highlight this and suggest government solutions.

  • Are we prepared to undo what has happened over time, which is this gridlock of interest groups, each of which essentially has a veto on any big change. Nothing else matters at this point.

  • The health authorities should operate like a business. In the business world, incentives and recognition are offered to those who increase efficiency and improve profitability. Outcomes are measurable at many levels, whether through a decrease in medical errors, re-admissions to hospital, patient care, and so on. If institutions are held accountable at every level to their regional health authority, we may see an improvement.

  • In the business world, when problems of this extent occur, it is a common practice to change leadership. This means replacing the administration staff starting from the top executives. These people have had plenty of time to resolve the situation and have been unsuccessful, so it is time for new leadership.
• In any area of public policy where we establish a monopoly, we require and impose legal obligations on the service provider to meet basic minimum service standards. It should be the same in the healthcare system. If we say that there is a single-payer system, then that system has to be able to provide some basic standards to citizens.

• We need to move from a culture of non-accountability to a culture more focused on measurable results.

• **Comments on local and external involvement in planning:**
  
  • There is a lack of local input and control. The provision of new facilities process is slow.
  
  • The Northern Health Authority is asking for and listening to concerns.
  
  • Why not put local Indigenous knowledge at the core of health service programming and policy planning. That is bottom up planning.
  
  • Citizens must play a vital role in re-inventing health care to make it work. In Australia, the Consumers' Health Forum was formed with government support after citizens demanded a place at the table. The association, a coalition of health care community groups, allows no providers or care workers or corporations. It publishes articles and reports, handles complaints, and speaks to the government on behalf of the citizens. A democratic health care system would foster other areas of development. Literature indicates that front line workers with more autonomy function better in more democratic workplaces.
  
  • You should be able to get bipartisan support for the principles and the long-term plan, and then you would not lose direction every time you change government.
  
  • Of course, sustainability is important and, to that end, we need government to stop crying that the sky is falling and be open to trying new ideas wherever they come from. If those ideas do not work, be ready to say so and try again.
  
  • How do you get that voice at a very high level of planning that is representative of a non-academic, non-systemic, non-health professional perspective? We keep designing research that maybe is not as relevant as it could be to the people that actually receive the services and deliver healthcare. The priorities may be different.
  
  • The Vancouver Island Health Authority must consider local interests and concerns in planning hospital facilities.
  
  • Planning must include the user.
Aboriginal and First Nations people were asked where they wanted the regional hospital and their preference was ignored. There were problems with affordability of homes and lack of support services.

Government has put themselves at a distance by using health authorities.

Community lead health allows the community to be innovative and creative with their health needs.

The community can best determine their needs.

Fraser Health must evolve to recognize aboriginal health councils as a partnership, not as an authority.

**Ideas and Suggestions**

**Planning Terms, Cycles and Linkages**

**Planning Responsibilities and Accountability**

**Local and External Involvement in Planning**

- **Ideas about planning terms, cycles and linkages:**

  - Planning needs to be directed at outcomes. The Ministry of Health determines what care needs to be delivered and how to achieve pre-determined objectives and funding is then spent accordingly.

  - Planning needs to be longer term and better coordinated, based on cost effective outcomes and driving towards change. The vision needs to be structured so it can be operationalized and it needs to be properly financed. To build this plan and the vision, we need to first think about the kind of health care system we need, then information technology and infrastructure become a means to that end and flexibility can be built into the system.

  - We need a plan, do, check, act cycle.

  - The government needs to commit to making the necessary long term decisions and supporting funding to ensure sustainability.

  - We need a planning framework related to health and health human resources, but it has to be underpinned by solid data and evidenced-based best practices.

  - The directional plan should include a vision describing what success looks like based on a needs-based analysis. The time frame of the plan should be projecting out 20 years, with 5-year planning increments. There should be a complementary information technology plan and capital plan.
• The planning process should focus on future trends beyond 2008 to achieve a long-term plan (five to seven years).

• Plan for flexibility. However well you plan at the beginning, there will be unexpected consequences, push back, and change and you have got to be flexible enough to adapt and move on as you discover new realities.

• Develop management guidelines. Specify the objectives and keep them focused (only five or six). Provide criteria by which success will be measured and define specific performance indicators for the management of all health regions. This will not include details on how doctors do their jobs, but it must include how the administration and boards manage the system.

• Focus on continuous improvement. You must constantly re-evaluate.

• Undertake evaluation of new programs.

• We need a risk management framework. We do not know what the real risks are.

• Drive the system to look at operations management principles. These principles drive an organization to look at labour allocation, equipment design, premises, room design and the like.

• Adopt the best of business models into the health care system: accountability, process improvement, measurement of results, best use of resources, efficient services, and use of best practices.

• Ideas about planning responsibilities and accountability:

  • Create a single governance body for strategic direction and outcomes, and restrict influence by politics and politicians. This body would set mid- to long-term goals, and develop proper metrics to know where costs and funding go, measured against outcomes.

  • The Ministry of Health needs to do long-term planning and share the plan with the public.

  • Government's role in health care should be limited to:
    a. Determining what public healthcare will cover;
    b. Setting the price of all types of care, operations, medications and all hospital stays that are included in public healthcare;
    c. Setting the maximum waiting period for all types of operations and demand they be met in the country or elsewhere;
    d. Setting the price of the annual healthcare insurance premium;
    e. Requiring that every person is insured; and
f. Requiring that insurance companies insure anybody who requests to be insured for no more than the annual premium.

- Government should set very concrete and specific health and quality goals, rather than telling health authorities how to achieve them.
- Government develops broad strategies, policies, targets for outcomes, and provides the tools and resources to do the job.
- Developing the plan is important. The Ministry of Health should be accountable for this plan and should lead its development. Ministries and health authorities should actively participate in plan development. They are also responsible for plan implementation and operationalization. There should be a continuous information exchange with a representatives forum. The plan must include a health human resources plan.
- Health authorities need to discuss their resource requirements with government, in terms of implementation of government strategies to ensure that this can be done effectively.
- There needs to be a stewardship perspective for whole system.
- Create new integrated planning processes and accountability structures that focus on the root causes of systemic demand to improve the health of the citizenry, integrate services and address social determinants of health (such as poverty). This is only achievable with strong political leadership.
- We need to have local decisions rather that having all the decisions made in Victoria.
- Health authorities must release business plans and other internal reports so the public can be better informed and better able to participate in policy decisions.
- Develop health authority, hospital and doctor report cards.
- We must hold the regions accountable for their budgets. More effective planning would result in more accurate and realistic budgets. There must be incentives for excellence and rewards for efficiency.
- Develop an accountability framework for transfer payments that would allow the Provinces the flexibility to use the money effectively.
- The public needs to hold government accountable for long-term commitments.
- Audit and continuous business improvement processes are required.
- There should be an organizational review by an independent third party with criteria and controls set and maintained by local communities.
• We need an independent audit of the entire health care system, including: where money is being spent; viability; efficiencies; creativity in the use of public funds; and creating accountability.

• Locally governed groups provide needs, feedback and input to one aboriginal led health council.

• **Ideas about local and external involvement in planning:**

  • Pressures will be alleviated by long term planning made by a citizens’ council on health which is independent of political and economic special interest groups.

  • Establish a strategic planning for health group. The group would be small, only two or three people that can provide specific advice on how to get the job of reform done. This must not be a high level group of thinkers only, but an implementation group. They would provide hands-on advice to the upper management of health authorities and the government. This group would initially get aligned with the Minister and focus on system reform concepts.

  • Involve the public and health care providers in strategic planning.

  • Health authorities need to understand what First Nations are entitled to. We need to collaborate to sort out services together. There should be stewardship of all health authorities for the whole system. They are all responsible for delivery across all health authorities.

  • Decision-making needs to be streamlined. We need to shift from a reactive to a proactive approach. If First Nations representatives are not invited, we should just go there and be in the room until they ask us to sit down.

  • The regional or local First Nations health authorities should develop plans to include a health advisory committee process into the health authority in their region or territory. This would feed into the provincial process for First Nations. Adequate funding would need to be provided for the process to be efficient and successful.

  • There should be information sharing and joint planning between the province, health authorities, regional hospital districts, and hospital foundations.

  • Encourage local planning, not top down. Make use of the expertise of the front line worker.

  • Local governments and the public should have significant input into the location of facilities. Local government should pay significant dollars towards health care facilities but should have a greater say into what and when facilities are built.
There should be greater inclusion of Regional Health Districts into health authority planning and implementation.

Increase the involvement of the public and employees in planning. The public would define levels of care and identify what is important. There would also be public education on the health care system. Learn from the Oregon experience, which included a lot of public involvement.

There should be education and resources to enable constituents to be involved in finding solutions through action plans, budget allocation, and resources.

Recognise in planning that one size does not fit all: urban solutions are not necessarily applicable to rural areas, and even rural areas differ from one another.

Government needs to include communities in decision-making on what is feasible and desirable in health care services.

**Governance Structures**

**Comments and Concerns**

- **Legal Governance and Funding Framework**
- **Accountability and Transparency**
- **Administrative Structures, Roles and Responsibilities**
- **Regional and Local Interests**

- **Comments on the legal governance and funding framework:**
  - Health authority boards are somewhat at arm's length from government and responsible for delivering health care to established targets within a given budget. They also provide advice on direction and strategies.
  - Health authorities see the current structure of six health authorities managed by boards appointed by government as being significantly more effective than the structure of the early 90s.
  - The Government appears to be increasing their control over health authority communications, making it difficult for health authorities to manage issues that arise within their jurisdiction, and to manage strategies and approaches to communications.
  - A number of overall governance responsibilities continue to lie outside of health authority responsibility, but have a large impact on health authority operations and performance (for example, delivery of primary care).
Review the 1960-70 models of administration.

The stronger the governance responsibilities of Boards, the more likely they will be to attract and retain world-class management personnel.

New Zealand's present system has twenty-one district health boards. These are composed of a mix of elected and appointed representatives. They are served by a secretariat and they must plan and fund a range of services for their respective populations. The district health boards are guided by the New Zealand Health Strategy, which contains a series of national health goals and targets. The system has a number of positives, especially that it is underpinned by a population health improvement philosophy. Also, there is a strong emphasis on reducing inequalities and boosting primary care. There are many negatives as well. One is that there are an extraordinary number of transaction costs, and confusion and complexity in running twenty-one separate planning and funding organizations for such a small population. At the moment, the country is going through a major debate about whether there should be a merger of some of those boards. There have also been difficulties with maintaining national consistency across a range of organizations.

What is interesting in the United Kingdom is that they have set up a model where they have created delivery councils, which are multi-disciplinary teams that operationalize various initiatives. They go out at both a federal and a local level and they gather funding to allocate it to the delivery council. There is always a lead assigned, but the operation then goes down to a local level. So rather than trying to change the government's structure, they are simply developing a new delivery model at the front line that is inter-disciplinary.

Nationalize health care in Canada.

Australia is a federated health system. The Australian government is primarily responsible for the financing of the health care system, while states and territory governments are primarily responsible for the administration and delivery of the system. This is an extreme form of vertical, fiscal imbalance, which is just a fancy way of saying that the commonwealth has all the money and the state and territories have all the responsibility.

Health Advisory Committees act as a conduit between the health authority and the community. The Prince Rupert Council has established a Health Advisory Committee.

We, in fact, are only partially regionalized. Huge arms of the budget remain in Victoria, for example in terms of what physicians are paid and the pharmaceuticals budget. We think we are regionalized, but in fact we have got one foot in the old
world and one foot in the new. This is partially why regional health authorities cannot follow the directions that come from Victoria. It impedes progress when drugs and physicians fall outside of regionalization. However, the regional authorities are not ready to take on additional responsibilities.

- Government has to take a more active role in determining where it wants things to happen. They should set the goals clearly and then back out of the way and wait for the right managers in the health authorities to deliver.

- All health care has been centralized in regional boards and boards are appointed by the government. Decisions made are top-down. Local hospital boards are not considered and are usually treated with disrespect or dismissal. The Chair has a corporate background and a life-line to the government, and so claims to know everything and does not listen to the health authority directors. Boards know nothing of rural and remote areas.

- Health authorities find the internal government departmental structure inconsistent with the goal of working effectively for patients. They advocate for more interaction between government departments.

- We have regionalized the Ministry of Health, but we have not regionalized the health care system.

- Perhaps a more useful role for modern health governors would be to protect the health system from politicians trying to micro-manage local crises on a daily basis. In British Columbia, these days are referred to as a Deputy Minister’s bad hair days. Such rules of engagement exist with the relationship between BC Ferries Corporation and the provincial government. Perhaps the best way of managing the health system is by forming a similar professionally managed BC Health Corporation with an independent board. This structure provides professional administration and accountability with minimum political oversight. This entity would be responsible for supervising the allocation of close to 40 per cent of the provincial budget. The challenge is that this structure denies politicians credit for expenditure decisions.

- The system needs to be departmentalized, with one person taking responsibility for each department. Every year the department heads of problem areas would be called upon to form solutions for cost cutting measures for the next year.

- Thinking national anything is big buck expensive, usually inadequate, and laced with extensive and expensive study.

- There is a regulatory division between the federal and provincial governments.
• The government ought to create regulations and enforce those regulations. Regulations that ensure doctors are qualified, hospitals are clean and properly equipped, and patients are treated in a timely manner.

• The province does not want to tell the regions what to do, and the regions do not want to be told what to do.

• Oversight of programs delivered at the community level requires different cultural governance than is required at the secondary, tertiary and quaternary levels of care. These cultural criteria are critical in defining the responsiveness of the respective governing bodies to the communities being served. Community based primary care, mental health or drug addiction programs have different needs and limitations that are usually expressed in real time. Centres of Excellence in medical research (tertiary/quaternary care) have to be planned for on a longer timeline, with stringent recruitment and investment decisions. Both these levels of care have to adopt different roles if they are to serve their respective communities.

• When I go to an emergency or doctor’s office, I expect to find doctors and nurses, not politicians or paperwork for politicians that the doctors are required to complete so politicians can approve medication or care. Keep the system public and get some medical professionals to run it.

• Should the province revisit the old model of hospital boards, or is there another model that might allow us to better utilize potential space or resources to address our particular needs?

• Health care is a complex system without a real governance system to unify it.

• British Columbia has a first class health care system, and it does not need fundamental changes.

• Health is a provincial and federal responsibility. There should be no initiatives or programs that result in downloading onto municipalities. Downloading will only result in duplication of bureaucracies. Regional districts should not hire medical experts. This is a function for health authorities.

• One of the hugest barriers in Canada to getting it right is the fact that we are so fragmented. Every province has its own system. Within every province, there are health authorities that have their own systems. Then there is the private system involvement. The Federal Government hands out money, and then the provinces hand out money, and then the health authorities hand out money. But nobody is minding the gate. The Federal Government has no responsibility for the delivery of health care and constitutionally the provinces do. It is a provincial problem.
• Health Authorities are only answerable upwards to the Ministry of Health and are, in essence, agents of the provincial government. Government is supposed to be the watchdog, but there is no one watching the watchdog. No one is responsive to the public.

• It is not the politicians that hold the vision, but it is the bureaucratic infrastructure that holds the vision. I would be interested to know what the demographic profile of our bureaucracy is, because if it is anything like health care, most of your people are between the ages of 55 and 65, and they are all going to retire in seven years. Who is going to take that vision going forward? Because we need that infrastructure support from government, the people in the bureaucracy who are going to hold the transition for the next 15 years.

• Each of the provinces has programs that are similar. However, each province has its own way of defining what these programs should accomplish and who should have access to them. Consequently, Canada does not have a national health care system. Canada has a national medical free access system at time of need. Understanding these differences became most relevant in conversations about the tendency of federal politicians claiming to be defenders of Canada's national health system, when the Canada Health Act only guarantees Canadians access to medical, diagnostic and in-patient hospital services.

• Health authority funding needs to be based in part on outcomes and patient satisfaction surveys. This goes not only for hospitals, but public clinics, clerical attitudes towards patients, response times from health authority officials to public inquires and how closely the health authority follows guidelines, mandates and directions from the Ministry of Health.

• We need to isolate political pressures from how the system is funded.

• Nothing is going well at the present time. It was going well before there was a regionalization. It was much less costly when there was an unpaid volunteer, elected board serving the hospitals.

• The current system of Health Authorities is costing taxpayers more money than the centralized Ministry of Health with elected Health Boards did 20 years ago. We are paying for administrators and administrative assistants and secretaries and liaison staff when most of us want to be paying for direct care. We want doctors and nurses and physiotherapists and the drugs we need to become healthier.

• The 2002 Health Authorities Act of British Columbia provided a legal framework for the government to transfer funding for all health and social services to five regions of the province and a provincial authority. Each region is under the oversight of a board of directors appointed by the government, whose mission is
to provide oversight in the administration of health and social services under one governing authority.

- Evidently there is a need for a legal mechanism, such as the health authority structure, to account for the funding transferred between the Ministry of Health and the regions. Such a legal entity is required to facilitate medical staff organizations and the granting of privileges to physicians who require operating rooms, and so on in order to practise their profession. Conversations about the independent solo medical practitioners in the community and the relationship some have with health authority boards can be most insightful from an accountability perspective. The model appears to offer full entrepreneurial privileges with little entrepreneurial risk for the physicians.

- Health Authority Boards are served by professional health administrators. Over the past thirty years Canada has created a cadre of highly professional health administrators. The spending practices administered by these professionals are usually designed to achieve the outcomes dictated by their Board. Within this paradigm, it is the Board to whom the Chief Executive Officer reports and who hires and fires the Chief Executive Officer. Is this the point of transition from political accountability to when a more professional accountability occurs?

- Canada is supposed to be a democracy. The decision to dissolve local health care boards and replace them with appointed regional boards has not improved health care or reduced costs.

- We need to first describe what improved health is. Is it increased longevity, more hospital services, increased access to drugs, or increased health care expenditures, and so on? Then our leaders should let those responsible for health care clearly explain changes they would propose and expected outcomes that would result and how these would be an improvement over current practice.

- Due to envelope funding, there is no ability to do a good job and expand services.

- Ideally, the Province should get out of the business of paying doctors and switch to funding medical services through the Health Authorities. It is the Health Authorities who can best determine how many family physicians they need in each area, and who are in a position to set appropriate targets for their area, and monitor what the practices are doing. These practices would also use a team of other health professionals (nurses, nurse practitioners, midwives, social workers, and psychologists, physiotherapists) to provide care when required. These other professions could be employed by the clinic, rent space there, or be in some other type of arrangement. It would be important that the Health Authority funds the practice as a whole, based on the number and type of patients served, and allows the practice to choose which physicians and other professionals to employ or
have an agreement with, although there should likely be a physician for every 2000 (say) patients.

- **Comments on accountability and transparency:**
  - Democratically-elected boards were dismissed in favour of highly paid government-appointed boards. This is more expensive as it comes out of our health budget.
  - We elect school boards, regional and municipal people, why not allow transparency and let us elect our regional health boards and directors? Elected representatives would choose the chair.
  - Medical care is a provincial responsibility therefore national control is unconstitutional.
  - The health authorities make a little information available on their web sites but not nearly enough.
  - It is very difficult to modify behaviour because there is no competition in the system. Physicians do not have to perform as long as someone gets access to them.
  - In order to shift the culture, people need to begin to be held accountable for their behaviour, starting at the top. Employees mirror the pathology of their leaders, and leaders need to acknowledge the role they can play in helping to shift the system. This requires that the ministry relinquish a bit of control.
  - The Government has given health authorities the power to review events confidentially in keeping with a no-blame review aimed at identifying and improving systems issues. The Government then turns around and contradicts its position by acting in a punitive and blaming manner. The continuous scape-goating of senior leaders by the Government creates mistrust within the health authorities and also between the health authorities and the Government. Firing senior executives does the opposite of what is needed.
  - Health authority administrators get a bonus for cutting costs, which impacts the delivery of services.
  - Consistency, accountability and transparency are needed, with skilled management at the working level, rather than the top.
  - There needs to be some form of guidance and accountability for individuals and health authorities.
  - It is the function of government to ensure that health care options are available to all areas of the province, and to ensure that the services providers are competent.
Health authorities are holding citizens for ransom and our government is allowing this to occur. By letting health authorities provide us with this low standard of care, our government has shed itself of this responsibility and is now not reacting to the health authorities’ shortfalls, poor judgment, and lack of short and long term planning.

When something goes wrong the health authorities just shout for more money and blame the government.

The decision-makers at the head of the Health Authorities really have no say in terms of budgeting and allocating resources.

A case management approach allows for clearer accountabilities.

There is no accountability throughout the system. The public receives services without signing off on the costs or having any means to evaluate the quality of the service. The doctors do not seem to be unaccountable to anybody and the system administrators, while reporting to boards, really do not seem to be performance-driven, as the quality and accessibility of the services deteriorates on an ongoing basis.

We need a larger role for the Ministry of Health including government letters of expectation.

I would like to see the administration of the health authorities take responsibility for the success or failure of their programs. They should be given adequate resources to make long-range plans with secure funding; they should be rewarded for providing efficient, effective health care, not for simply slashing programs to meet budgets, and they should be held responsible for their failures.

Everyone should be accountable for every dollar that is spent. All facilities funded by the Ministry of Health should be audited by an independent auditing firm to ensure that monies are being spent wisely and not misused.

The range of oversight organizations in other jurisdictions includes health complaints tribunals or ombudsman. They can look at corruption, quality of health care, and performance of health authorities relative to a range of indicators. It can be an independent oversight organization.

We need to get health authorities looking beyond acute care to the full responsibility for primary health care. They are now doing that in New Zealand. That is the direction we all need to go, so health authorities can make rational decisions across a wide spectrum of services that influence population health outcomes.
The way the regions are constructed is much more efficient at providing sick care. You have multiple communities of moderate size distributed over vast areas. In most of those communities the actual acute health care system has improved in terms of the number of specialists because resources are pooled, and not everybody is doing the same things.

We do not have any transparency or factual information on the accountability of Health Authorities.

The public is not a force to drive policy within health authorities.

Each health authority region is independent of the others for delivery.

Health authorities are micro-managing health and they are bungling the job. People are suffering as a result.

Since many individual health cases are raised in the Legislature, the Minister, and consequently the Ministry, are drawn into debates around issues that belong more properly within the purview of the health authorities. This issues management approach also tends to detract government and the Ministry of Health from consideration of long-term and complex policy questions. Health authorities recommend that these issues be referred back to the health authorities rather than continuing the debate in the House or through the media.

Health authority boards have left clinical care to doctors, even though it is a board responsibility.

Every community has a right to a fair and efficient process for resolving differences with their health authority, including a rigorous system of internal review and an independent system of external review.

There is a total intransigence of the Interior Health Authority, including management level staff, to accept any input from the public.

Over recent decades, the system in British Columbia has witnessed transformation from a provincially directed structure with effective local input, to one now dominated by regional health authorities. Positive elements of this, such as flexibility, are counterbalanced by negative ones, such as artificial barriers to sharing of information and budget responsibilities. Accountability has not necessarily benefited, nor is the expertise at the regional level always sufficient to speak either to the larger provincial need, or to locally unique needs. This aspect of the province’s system design should be revisited to examine potential for improvement.
• The financial problems and unwarranted secrecy of the present unelected health authorities indicates an ongoing massive failure of the province (Ministry of Health) to control spending and fully ensure effective provision of health care services to all British Columbians, and to ensure that there are sufficient fully qualified medical and nursing staff to provide fast efficient service, especially in the emergency rooms.

• There are no consequences to government as a result of making poor decisions or mismanaging the system. Health authorities have too much control without accountability.

• The further you get away from where services are delivered the less connected they are. You cannot sit on the top floor and deliver effective services. Managing a billion dollar system centrally is not working.

• We have to re-think the Ministry of Health. We always think about it as the Ministry of Illness. So much of the budget goes to illness, not to health.

• The health authorities do have a variety of accountability mechanisms that are supposedly designed to hold our collective feet to the fire to help us achieve provincial goals. This is where there could be areas for improvement. The government letter of expectation in the future could be more focused.

• There is no accountability to the public from the health care system.

• The government should either strongly support and apply the principles of quality management to the health care system, or explain to the public why they will not. Quality management can be applied to any system.

• There is a lack of ownership with regards to shortfalls.

• **Comments on administrative structures, roles and responsibilities:**

  • With the emergence of highly competent public administrators in both provider organizations and the central funding agencies, and the increasing development of population health based e-health authorities, the traditional role of health governors, besides their fundraising duties, appears to be becoming redundant.

  • There is a brave new experiment in British Columbia over the last five years with the creation of the health authorities of a certain size. If you go looking elsewhere, health authorities have been around in various forms in other countries for many years and there is plenty to learn about out there and it is really exciting. One has to question whether or not we have finished with the evolution of the health authorities or whether we should, in fact, rethink what they are doing.
- From an administrative standpoint health authorities perform a useful function. However the current corporate philosophy tends to exclude or marginalize appropriate patient care and acceptable outcomes.

- The decision in 2001 to create six mega regions was interesting. After three or four years of stumbling, the regions seem to be finally figuring out how to work. Do not do away with health authority boards and create one provincial board.

- Look for a different delivery and management model. The direct management by the Ministry of Health has been proven not to work. It is bureaucratic, unresponsive, expensive, and inefficient, delivering an unacceptable product quality. Some models to look at would be something that is more reflective of private industry, with more accountability and a market-driven component. Review other successful pseudo-Government organizations such as the Insurance Corporation of British Columbia. Even a Crown corporation structure or another structure that would get more performance-driven management and accountability into the system and allow for a market-type enterprise with accountability, incentives and motivations for those in charge.

- Employees should have been consulted before health authorities were established.

- The structure of managers reporting to managers might not be needed if staff was more empowered and authority shifted down towards front line staff. The current pyramid needs to be turned upside down, with front line workers at the top.

- One has to ask where our democracy is when the few people at the top of the pyramid totally ignore the majority. Before the province ended the Health Councils, every area had some elected officials who were accountable, and they were volunteers, not costing the tax payers the huge amounts that the current regional boards do. We now have to pay more for less. Where is the cost saving in that?

- Micromanagement has been shown to not work in any business and health care is no exception. The decisions that have been made for health authorities over the past two years have been increasingly government controlled, unwise, short-term, simplistic, political and damaging to the health care system in the long run.

- When the health authorities were set up there was no corresponding geographic response with respect to social services, so right away you have dysfunction at the core of the health system.

- This province has identified the health authorities as the custodians of the health of the population. If we do not like that, let us get rid of it. If we believe it, then somehow we need to build upon it. We are not there yet.
• The move to six health authorities from what were 52 distinct authorities has been an important step ahead.

• Recent changes to the Board appointment process have seen responsibility for this within government shift to a departmental role. There is a concern that grouping health authority appointments with other government appointments will undermine the overall importance given to health authority board appointments.

• Appointees to health authority boards do not care about rural communities, are not impacted by their own decisions, and are often ignorant about vital aspects of the delivery system.

• Regionalization results in doctors leaving their offices in outlying centres and moving to the vicinity of a regional hospital.

• The ones who should be in the driver’s seat are the people and not the physicians or the other health care providers.

• As a result of the structure of governance through the Ministry of Health and health authorities, there are multiple layers of bureaucracy.

• Inexperienced people are appointed to manage branches and then when they screw up they just get moved. There should be some recall for those in charge who do a bad job at managing.

• The present institutional infrastructure is mainly concerned with reducing the liability of the institutions and practitioners within the system.

• Put Ministry of Health staff energies to something that adds value to the system instead of being demanders of trivia.

• Many complaints have been received about the pressures put on middle management by the layers of management above them. Over the past few years, a large number of middle management personnel have resigned out of the sheer frustration of being given impossible tasks.

• The relationship between the provincial ministry and health authorities is fraught with disrespect and inconsistency. Everyone is building an empire.

• **Comments on regional and local interests:**

  • It is natural that people are concerned about problems at the local level, they want to participate in finding solutions and want a say in the management of issues that they care about. The challenge is to decentralize political power through citizen participation at the community level.
• Vancouver Coastal Health maintains four Community Health Advisory Committees as part of its overall governance and accountability structure. The mandate of these committees is: To assist Vancouver Coastal Health in establishing mechanisms for ensuring public input throughout the region as mandated by the Ministry of Health.

• There needs to be a focus on community needs and delivery models. The health authorities are run by a bunch of people with no accountability to anybody in the community. When you make presentations to open board meetings (when they have them), the board goes away and you never know what happened with your input.

• We need to decentralize planning and budget allocation and focus on community-based decision-making.

• The Province is downloading health cost pressures to local governments.

• Regional inequalities must be addressed, including: acute care bed ratios, long term care bed ratios, community supports and diagnostic facilities as well as the availability of health professionals.

• The centralization of services leads to a reduction in rural capacities and eventually reduced community viability.

• Almost without exception everybody sitting on a health authority executive has an acute care background. The future is in the community, but we default to acute care.

• We do not know Board mandates from Government. Board members represent government not the community.

• Regionalization of health centres is a good idea.

• There is a loss of relationships and no link to community through health authority boards.

• During the regionalization process, small communities lost their voice and the ability to manage their own facilities and hospitals. Centralization of provincial administration, with provincial standards and local input and decision making, would be more efficient and just. Also the economics would improve.
Ideas and Suggestions

Legal Governance and Funding Framework
Accountability and Transparency
Administrative Structures, Roles and Responsibilities
Regional and Local Interests

- Ideas about the legal governance and funding framework:
  - Make health care universal across Canada with one health authority based in Ottawa. This would result in cost savings and is consistent with many European countries which only one health authority.
  - Consider the United Kingdom governance model, which is a Public Benefits Corporation. This would decrease political interference in health service delivery.
  - There is so much overlap and duplication in some of the things we are trying to do that we need to think more creatively. We need to move to a regional concept where provinces as partners are delivering certain aspects of health care. We provide a lot of services to people in the Yukon and the Northwest Territories here in British Columbia. We also send people back and forth between Alberta and British Columbia.
  - Increase health authority autonomy.
  - Health authority boards need to be governing bodies, and not have the role of advisory bodies.
  - Government needs to allow Boards to govern their health authorities without detailed management by government or the Ministry of Health.
  - Government should stop micro-managing health authority boards.
  - It is recommended that, along with exploration of more functional funding models, the Ministry of Health work with primary care organizations to develop robust effective governance models to share with the practicing community and offer them as companion elements in implementing the changes canvassed in this document
  - Expand and confirm our national standards for all.
  - There should be sub-regions for health authorities, particularly larger ones.
  - Form an independent entity that is free from government involvement, and managed by a consortium of health care professionals.
  - The Ministry of Health should take over responsibility for all hospitals and clinics and disband the regional health authority models of governance. Administration of these models would be eliminated as well.
There should be one overall Hospital Management team overseeing all of British Columbia’s hospitals and have sub-groups in each hospital.

The provincial government should put an end to the health authorities and allow the Ministry of Health to do the job it was designed to do. Health care is not a business but a service.

Primary care and chronic care are linked and are seen as among the most important areas on which we should focus. As a result, primary care providers should be brought into the system.

Get rid of health authorities.

There should be a review of the overall responsibilities for health across government and health authorities. This review would include a question of whether the responsibilities are within the purview of the right department or organization.

Re-evaluate the health authority model.

There should be Aboriginal health authorities.

There needs to be a mechanism to facilitate policy and legislative change within government to allow health authorities to implement innovations and changes. Often these policy and legislative changes take too much time to help health authorities meet their business goals.

Health authorities need an opportunity to discuss strategies and policies under development with government.

Government, with health authorities, could investigate a Crown corporation model of governance, which has an enhanced ability to do long-term planning, and would include the Ministry of Health and health authorities. There was a suggestion that this may result in a more coherent governance and accountability framework and would isolate government from day to day issues management and operations.

Administration may be able to be better managed in a Crown Corporation format with a President and Board of Directors functioning at arms’ length from the political authority.

Break down barriers created by competing self-interests by creating a strategic top level body responsible for developing a complete health and wellness system from cradle to the grave. This is a strategic governance model that requires a paradigm shift to wellness care including the social determinants of health.
• The Ministry of Health is responsible for creating public policy in collaboration with health authorities, physicians, health professional unions and associations, and local government.

• There should be a Cabinet level coordinating committee for human services in government.

• We should have duly elected Hospital Boards returned to ensure accountability to the people.

• We need to elect the health authority board to ensure accountability. We need an opportunity to direct the health authority, especially around budget and capital spending.

• Deliver health care funds in a coordinated manner across urban and non-urban areas.

• **Ideas about accountability and transparency:**

  • Increase public accountability. The activities of the various health bodies should be regularly published on the Internet so that the public can learn about what they do, how decisions are made and perhaps begin to understand some of the difficulties.

  • Regional Health Services are the way to go but it must be through 15 directly elected regional councils (including one for First Nations communities) throughout British Columbia that would be fully and openly accountable solely to the public (taxpayers) and not the provincial Minister of Health.

  • Increase Health Authority accountability by: requiring government and health authorities to annually publish status reports on their progress towards satisfying accessibility criteria, such as wait times; linking health authority performance assessment to patient outcomes in addition to expenditure targets; and, giving Health Authority Medical Advisory Committees (HAMACs) responsibility to submit, on an annual basis, a public and independent report to the Health Authority Board of Directors on clinical issues.

  • Accountability is focused on the wrong aspects of health care. It should be focused on population health.

  • We need an independent organization in each region that has the power to report on the health system, similar to an auditor general.

  • We need a health watch dog.

  • Broaden health boards to include members of public and health care workers.
• Have open board meetings and consult communities. Make health authorities more visible.
• Set a universal standard for care across the country.
• Set quality of care and access standards, and have a system for establishing them, making the system accountable to them, before we consider changing our delivery model.
• We need to establish a system of accountability to the public through citizen participation.
• There should be more public consultation.
• Increase the number of elected officials involved in delivering health care.
• Put health professional representatives on health boards.
• We need systemic change around accountability structures.
• Create an accountability framework tied to current needs and outcomes for the non-profit sector.
• Provide quality, timely and cost effective health care with a patient focus to all residents as close to home as possible.
• Competition should be regional and national, not just local. Why do people go to their local hospital with cancer? Because they have no idea who is best. If you had a cancer that is killing you, you would want to go to the best Cancer Centre.
• We need transparency to understand what is happening in the health system. Report everything. Make it all public.
• Any changes to the system should have value for all three stakeholders: patients, payer, and providers.
• We need to embed system-level accountability: to patients and the public and to the multitude of stakeholders.
• Align incentives and targets with goals.
• Health Authorities need to become more pro-active in providing accurate, clearly understandable and regularly accessible information to seniors and the general public on matters that are of concern to seniors.

• **Ideas about administrative structures, roles and responsibilities:**
  • There should be seniors on health authority boards.
  • Encourage health authorities to cooperate and share ideas and resources, but stop dictating or directing policy. The health authorities need to own the policy,
not pawn it off on the Ministry of Health to create so they can botch the implementation or point fingers at the government when clients complain.

- There needs to be balanced talent on the boards, not just financial and big business.

- We need a balance between central and local methods of decision-making.

- The Government should create facility advisory committees for each area served by each health authority to improve accountability of the facilities and authorities.

- Regional health authorities are not communicating. They need cooperation and an agreement on what will be implemented, how things will be integrated, scope, timelines, leadership, multi-government, and long term commitment.

- Information technology and infrastructure are strategic components of the business of health care. As a result, health authorities should own these assets and manage them to ensure they benefit health authorities.

- There needs to be a greater diversity of representation and perspectives on boards.

- There is a strong desire for improved collaboration and communication between health authorities. A secretariat devoted to this purpose would help to ensure that this happens.

- Health authorities need to get out of all business unrelated to health and focus on core health service delivery.

- Use volunteer health boards not paid chief executive officers.

- Integrate physicians and drugs into the regional health authorities.

- Make management accountable for efficient and effective systems.

- We need to set-up a permanent process to monitor the healthcare system globally, looking to cherry-pick the best ideas.

- **Ideas about regional or local concerns:**

  - Community focus and direction must be developed within health authorities to allow for a non-political direction and initiatives from communities, including Aboriginal communities.

  - Establish local or community advisory bodies.

  - While government might be concerned with the operation of some of the health authorities in the province, do not give up on the model. Regional health planning and service delivery is the correct structure. Do not give in to calls for local government appointees to these boards. Regional Health Authority Boards must
make decisions on behalf of the region as a whole. Local representation will only introduce parochialism into the process.

- A health council with a delegated authority could become a way into the community.
- Dissolve regional health authorities and replace them with locally elected volunteer health boards.
- Aboriginal people should come together to design a health council, and they would define and determine the most pressing health issues.
- Breakdown jurisdictional barriers affecting delivery of services to Aboriginal people and communities.
- Integrate and partner.
- The delivery of health care should be solely at the provincial level.
- Health programs and services must be developed locally based on traditional values and practices.
- Give back all the hospitals you closed to the communities at no cost. You stole them without compensation. Allow them to function on a non-profit basis. The provincial government would pay these hospitals the equivalent cost of a bed in a current hospital. Doctors using these hospitals would be entitled to charge for their services.
- Hospitals should again be under local control.
- We must allow the provincial government to have greater flexibility and control over how the public sector's delivery of health care should be managed.
- Keep primary level care as community-based, including salaried staff. Retain tertiary care as regional resources with a combination of salary and personal services contracts.
- Decisions regarding seniors should be made at the local level.
- If a local government is willing to fund facilities to a higher level in Fort St. John than Prince Rupert it should be allowed to do it.
- There should be decision-making at the local level including through regional hospital boards. There should be citizen committees.
- Embrace more community-based decision-making.
- De-centralize services.
- There is a need for shareholder accountability in the delivery of public health services provincially and nationally.
We have lots of figures and research that suggests municipalities can have a significant role in terms of health care.

Create flexibility in the framework to suit the community.

Create healthy communities funding to include a supportive role of municipalities, regional districts, First Nations, the educational sector, and so on to improve public health and overall community wellness.

Consider a village structure where the government sets standards and provides funding but does not run the system.

Health programs and services must be developed locally based on traditional values and practices.

Accountability and spending should be decentralized.

We need something that is provincial, that lays out the principles, but needs to be responsive to the local reality too. Delivering care in Fort St. John will be very different than an urban environment in the Lower Mainland.

Service delivery should be based on populations (for example, seniors, young adults, and aboriginal).

Vancouver Coastal Health has divided up the city into community health areas. Each community health area has one or two community health centres to deliver traditional health services on site, or through an outreach model. They have relationships with contracted not-for-profit agencies. We have not gone far enough in terms of looking at the range of services that need to be co-located there. You could look at that sort of community based one-stop-shop model and increase the range of services provided.

In order to address the many health concerns that affect the fifteen municipalities and three regional districts, the Northwest Municipal Association requests that the Ministry of Health update the Northwest Health Services Plan.

Health authorities should cover smaller areas.

In the north, there should be more than one health authority.
Performance Management

Comments and Concerns

Approaches to Performance Measurement
What to Measure
Availability of Data

- Comments on approaches to performance measurement:
  - The current focus on accountability through performance agreements is seen by health authority boards as a positive step.
  - There seems to be an inability to root out even the most irrational incentives in the system.
  - The current government letter of expectation to health authorities appears to set clear performance measures without equally clear benchmarks, making it challenging to plan for, or achieve, the measures established.
  - The government letter of expectation to health authorities appears to place more decision making authority in the Ministry of Health, affecting the overall governance structure. The letter of expectation has moved from a high level directional document to much more detailed instruction, which has inconsistencies with a board model of governance.
  - Primary Care suffers from a major dearth of measurement. The reasons are many, including a major lack of information technology infrastructure in primary care, dependence on a payment system which reinforces an episodic approach to care rather than a population base, and lack of standardization in data terminology, aggravated by a dependence on a disease nomenclature which is inappropriate for primary care. As the amount of alternative funding grows in British Columbia, the completeness of fee-for-services data as a source of population-based information decreases.
  - Outcome measurement is a good tool for determining change in health care services. A more thorough look at diverse research in health care, including health promotion, prevention and early intervention will likely yield better choices with respect to the direction of change.
  - Measurement is a tool for all four system levels in health care. Patients can use measurement to self-manage components of their own care, for which they require tools and education. Practices need measurement to know who they are serving, who is receiving care and who is not, and who has achieved health (promotion, prevention, treatment) goals and who has not, how long care takes,
what it is costing, how patients perceive care, and so on. Health organizations need measurement for most of the same needs, and for assessing where needs are within their domain of responsibility. Health systems need measurement at a similar congregate level, for broader policy and outcome analysis and planning.

- Measurement generally does not just happen. It needs stimulus, support and tools, ideally those which can capture data of relevance in the course of activity, with a minimum of additional work.

- There are two really significant parts of the performance measurement framework in Australia in Indigenous health. The first is the Aboriginal Trust around the health performance measurement framework, which included adding domains grouped into three tiers: health status and outcomes that determine self health and health systems. It was actually developed off a Canadian model. This approach significantly shifts the focus of performance measurement onto the health system as a whole.

- When all services were administered in Victoria, standards of care were developed by teams of specialists, which resulted in consistent care across the province.

- Governments should be very precise about what the goals are and then turn the system loose to figure out how to do it with a lot more flexibility. Regional health authorities have far too little authority. When I read in the paper that the Ministry of Health says to Vancouver Coastal, 'You have a $40 million deficit. We don't like it. Take it out of your travel budget. And by the way, you can't cut any services,' it is just not logical.

- Performance agreements are not being adhered to.

- High performing health systems establish much stronger accountability among physicians through measurement and strong contractual relationships around service provision and performance. You need less clinical autonomy. When there are variations in practice, people do something about them. It is a hallmark of quality improvement that people doing the same things in the same circumstances will produce higher quality outcomes than people doing vastly different things in the same circumstances. What distinguishes Canada from almost any other healthcare system in the world is the degree of clinical autonomy. We have a phenomenal tradition of clinical autonomy. Clinical autonomy, of course, is a good thing for a professional and probably for the professional's charges, their clients, but if it is not combined with good measurement of performance and accountability, you end up with a quality problem. And I think we are facing that in spades in this country.
Performance measurement and information related to it must be transparent. For example, when the Interior Health Authority performance agreement was obtained by Freedom of Information most of it was blacked out. A non-partisan auditor needs to put forth a summary of the Interior Health Authority performance agreement with an evaluation of how they have done with appropriate, binding interventions and recommendations. British Columbia has a right to know how our money is being spent.

If you do not measure results, then you get this equation: Value equals the inverse of the cost, that is, the best program is the cheapest one, which is the one with the least service. Now this is an obviously absurd result, but that is where we are. We do not measure the results. So what we end up looking for is the cheapest programs and the ones with the least service.

There is no apparent connection between the variations in patterns of care, and the needs of patients and the outcomes. You need both databases of responsibility and accountability from which to try to bring together divergences in how things are done. Variability is natural. A lack of variability would be a big problem because we could be stuck in this state. But in the end, government or the payor should actually have a good sense of what they got for their money, because they do not have that now.

**Comments on what to measure:**

- In most countries health care is not thought of in terms of products. If you do not measure outcomes and cost, then you cannot know who is better, faster, and cheaper.
- There is a lot done by the Canadian Institute for Health Information around performance measures. They catalogue lots of categories of things that go on in the health care system and they do comparative analysis between provinces and health authorities.
- Patient satisfaction is actually a robust measurement for overall function. At the end of the day if patients are better served, they are happier.
- It is inappropriate to set outcome indicators for regional health authorities unless you include the physician groups in a model of best practice accountability.
- Patient outcomes are the responsibility of the health authorities. If a pattern at a particular facility or with a specific service develops then it is the job of the health authorities to find solutions.
All health authorities and physicians should be funded only on the basis of health outcomes. It troubles me that our addiction levels, obesity levels, incidence of chronic diseases are all increasing. Yet, health authorities have responsibilities and jurisdiction over these things. What are they doing? Where is the accountability?

You can be either tight on the outcomes you are going to achieve and free the system up to get to those outcomes, or you can be tight on the process that you ask people to follow to give you all the outcomes. We need some very clear management. For example, the United Kingdom established some rigorous targets for delivery and then put some money into the system. Here we establish targets but do not invest in achieving the targets, nor do we develop plans to achieve the targets.

There are no measurable gains that can be evaluated or checked against current standards.

Outcomes require more time to occur and measure than is politically acceptable.

We need measurable markers of health across the lifespan.

Accountability to the Ministry is through service agreements but they do not require that we measure health outcomes and utilizing best practices. Accountability is in the wrong places.

We decided not to measure infant mortality, maternal mortality and morbidity as those numbers started to fall.

What indicators do other provinces use?

If physicians are appropriately supported, they are able to provide comprehensive care and measure their success using patient satisfaction surveys.

Today we measure the patients’ length of stay, not the outcome, what it is costing, what the complications levels are, and what the readmit levels are. We are measuring patient days per 1,000 people. We are not measuring health.

We need to stop counting the things that are easy to count, and start counting the things that count.

In Australia, some people say that they do not really want to measure inequalities because that measures us against a non-Indigenous norm. I want to measure inequalities because I do not want to monitor Maori health but I do want to monitor the Crown’s commitment to Maori health.
• It is essential to know where you start from. We need to converse about who is Indigenous, provide systems for counting, provide education and training, and make sure that we move forward with complete, consistent and continuous data.

• A rights-based approach is to honour people by counting them. After we have decided who has the right to be Indigenous, we must honour Aboriginal people by counting them.

• **Comments on the availability of data:**

  • There are national surveys that happen through Statistics Canada every year, which are helpful to some degree. But they are not at an adequate level of granularity to be useful. So I think just overall, we need to look very carefully at the information we have. We need more focused information on the social determinants of health.

  • Family physicians should invest in studying epidemiological data to understand their impacts on the communities they serve.

  • There is data that is sufficient to get started and support decision making.

  • We do not have a good acute care financial tracking system.

  • We do not have an accurate picture of the costs of individual procedures and services.

  • There has been lots of work done to develop 146 indicators, most of which we do not actually collect in our data sets. So we should at least collect a few useful indicators as a province that each health authority can have so we could report to our boards on progress.

  • There is a lack of consistent data from health authority to health authority.

  • We do not collect enough data on quality issues.

  • Data is missing in order to properly measure outcomes. For example, the Kelowna Accord is focused on five outcomes because they know to address inequities you have to focus on outcomes. But they may not be outcomes. British Columbia signed off on them, but there is no data on any of those outcomes. How is it at this high level policy discussion with all the chiefs, all the national Aboriginal organizations, all the Ministers of Health, and the Prime Minister’s office that no one put up their hand and noted that, while the outcomes are good, there is no data. For example, we do not know what the rates of childhood obesity are. We do not even know how many of our children there are in the province.
Ideas and Suggestions

**Approaches to Performance Measurement**

**What to Measure**

**Availability of Data**

- Ideas about approaches to performance measurement:
  - Institute a province-wide system for tracking safety and quality standards. Ensure that hospitals do not allow unnecessary operations.
  - Make a culture of accountability the cornerstone of public health care.
  - Create an accountability office to recommend system-wide changes.
  - There should be no bonuses for saving money in health care.
  - Foster the idea of corporate responsibility
  - Provide bonus points for meeting targets and improving quality. Incentives for quality care targets can be a catalyst for getting people out of their old patterns.
  - Look at local targets and management, but report provincially.
  - We need funding in order to meet targets, otherwise it is just a bureaucratic exercise.
  - Health authorities must be accountable for the implementation of guiding principles.
  - Get performance agreements that focus on positive improvements in the health status of the community with an agreed set of indicators of a population health nature. Health authorities would then be given the tools to make the decisions they need to achieve those outcomes.
  - Practitioners need to be accountable for their patient outcomes, not just the process. To do this, we need to improve our approach to measuring outcomes. Similarly, we need to move to a longer-term planning and budget cycle.
  - Create a results-based system instead of system that rewards the number of procedures done.
  - Set goals and specify results.
  - We need to identify who produces good results, and how much it costs.
  - We have to measure outcomes and provide rewards for positive outcomes.
  - We need to decide on the systemic changes we want to make, and then determine what success would look like. Then we must determine what performance measures we need to use to measure when we have achieved that
success. This can be done through setting annual targets. By the first year, there should be some measured improvement.

- Create an independent non-political evaluation of performance agreements with mandatory, binding decisions.

- Health authority performance should be assessed on efficiency gains: reductions in waiting lists, dollars spent (including staffing costs) per procedure in each department, complication rates, and employee turnover and morale (using employee surveys).

- Fund health authorities based on how well they do their primary job: delivering healthcare to their constituents.

- Funding to health authorities should be based on the population they serve and the particular services and expertise they provide.

- **Ideas about what to measure:**
  - Government should shift health authority funding to a mix of block and service-based funding to improve performance. Health authority performance assessments should be linked to patient outcomes in addition to expenditure targets.
  
  - Make health authorities accountable for deaths.
  
  - There should be more accurate reporting of how our health dollars are spent, not just whether we are going to increase the budget, but detail on how the money will be distributed to programs, services and equipment, and so on.
  
  - Establish health targets to determine our success. We need to identify what we want the health care system to achieve both in terms of health status and health outcomes.
  
  - We require qualitative measures and a rating system for facilities.
  
  - Measures need to be specific for the populations with which you are dealing. For example, look at the particular needs of the Aboriginal population and set measures to address those needs.
  
  - Accountability needs to be in ways other than fiscal.

- **Ideas about the availability of data:**
  - Publicize key health care indicators and outcomes for the regions and make them accountable. Provide comparative data from systems in Europe and the United States.
  
  - Undertake a forensic, impartial audit and reporting of health care expenditures.
• Establish the cost of hospital performance before and after bed closures, decreased surgeries, and staff reductions.

• Encourage graduating students and universities to partner with communities to get measurable data on health care goals.

• We require better accountability and data on home support from health authorities.

• Create transparent expectations which are measurable, so that British Columbians know what to expect from services and treatments.

• We need a data base so that we can, on an annual basis, see what progress the First Nations communities have made, to be able to see where the gaps are and what we need to do to make the necessary alterations to achieve our objectives. For that to be done, we need to go into the communities.

**Health Authority Administration**

**Comments and Concerns**

*General*

*Specific Health Authorities, Services or Facilities*

• General comments on health authorities:

  • Health authorities are not effective.

  • Health authorities are top heavy with management.

  • Health authorities fail to listen to the public and the front-line staff.

  • They do not make their performance agreements, data, financial statements and other reports available to the public or easy to find.

  • Board membership is skewed to a business perspective.

  • Decisions are having a negative impact on population health.

  • Smaller communities have fallen through the cracks.

  • Regionalization has not resulted in flatter organizations or more community input (closer to home). It has resulted in large corporate organizations that are top heavy with consultants and analysts and low on front line workers.

  • Too much money is being spent on wacky administrative costs.
• The health authorities operate in the absence of public scrutiny and accountability and therefore the public is usually unaware of a problem until it comes to the media’s attention.

• Communities and patients no longer have meaningful influence over health policy. Until it is re-established as part of the health authority corporate design, we will continue to witness the problems being exposed on the six o’clock news.

• What is never mentioned is that we have physicians accepting payment from the public system, using publicly-funded facilities at no cost to themselves (for example, operating rooms, laboratories within hospitals, and so on) with accountability only to the patient.

• The problem with our health care system is that no one knows the real cost of procedures, health professionals time and even medical supplies. Once these costs are determined all items should be charged on a per use basis. Everything else in the world is paid for according to a specific price. Once we understand the real cost of health care, our provincial health authorities should be provided with money based the actual cost of the health care, not uneducated guesses.

• There is an apparent misspending of health care dollars by health authorities. The use of extremely expensive facilities for meetings with full catering and all the trimmings is very costly and the same could be achieved by having meetings at more reasonably priced facilities without having to go on retreats. There are too many perks for the people running the authority and not enough going into the actual care side of the business.

• Health authorities are top heavy in administration with excessively large salaries.

• Health authorities have ballooned with their administrative empires as they become similar to large corporations. Health dollars are going into corporate positions intent on centralizing systems and procedures, rather than going into direct patient care.

• Health care in the health authorities has placed the administrator and Chief Executive Officer as the top of the pyramid instead of the patient.

• It is a waste of money to spend $100,000 to teach staff to wash their hands.

• What is wrong? Not lack of resources, but mismanaged resources. The priorities within the health regions are all out of kilter. As long as management within the health regions is solely measured by their ability to stay under budget we are going to continue to fall further and further behind the rest of the developed world in terms of access to care.
· We should expect the health authorities to be operating efficiently and with due diligence. We should expect the highly paid and educated administrators to be able to manage a budget based on the needs of the area that they are managing. This would help to utilize health care dollars more efficiently. The government could audit the health authorities to make them accountable for their spending decisions.

· Health authorities do not seem to understand local concerns or stick to budgets.

· Front line managers spend too much time on budgets and not enough on improving processes to improve care. They should be auditing more to ensure care needs are being met satisfactorily.

· Health authorities need to be run by qualified and wise Chief Executive Officers who will stick around for a long time. The longevity of Chief Executive Officers correlates to successful organizations.

· Health authorities waste money on one restructuring after another.

· There are too many contractors paid exorbitant hourly fees and there does not seem to be any cohesive organization of redundant projects and programs as these over-paid contractors milk the system by coming in and getting out. They then move on to yet another health project, often taking the expertise that they have gleaned from their previous position so the health organization is left starting again.

· The non-profit sector is vigilant in accounting for its revenue and expenditures and has accountability is to its donors, Revenue Canada and its board of directors. It publishes annual reports to its community and raises awareness through stories, donors, media, advertising, programs and services. You do not see this connection with community from health authorities.

· Health authorities do not respond to First Nation inquiries about why their project proposals and initiatives were not successful.

· **Comments on specific health authorities, services or facilities:**

  · I can only speak highly of the Vancouver Island Health Authority.

  · The North Vancouver Island Regional Hospital is scheduled to be built on agricultural land. There are no First Nations or Aboriginal people that live nearby. It will cause a larger barrier to access to our most marginalized, lowest socio-economic groups of the North Island, with a population profile of young moms and children. We have time to change the location to Campbell River.
Fraser Health appears to have the responsibility without the ability to control the key inputs, the patient demand and the surgeons. If [health] providers are expected to innovate, they must have the resources to do so.

We do not want a public private hospital in our area instead of two non-profit community hospitals, which is what we currently have. The Vancouver Island Health Authority has only listened to the profiteers (some specialists, developers, private corporations). They have not listened to us, the tax payers and patients, and the notion of accountability to us has been swept away by greed.

I am hearing about growing administration at Interior Health but I am not hearing about decreased resident and care-worker ratios.

The Interior Health Authority has gone back on its commitment to re-open Deni House.

In the Williams Lake area, the Interior Health Authority shut down all public run facilities under the guise they were old and repairs were too expensive.

The health care system in the Northern Region is appalling. Simple communication should not be an issue.

At British Columbia Children’s Hospital, we experience top professional care.

Stop punishing the big health authorities (Vancouver and Fraser Health Authorities) for going over budget. What on earth are they supposed to do with the demand being so high?

The high profile resignations by the Chief Executive Officer of the Fraser Health Authority, and a member of the board of directors of the Vancouver Coastal Health Authority in response to the firing of the Chief Executive Officer of the Vancouver Coastal Health Authority, for a $40 million shortfall just shows that this $10 million Conversation on Health is a total waste of time and money.

The Interior Health Authority has closed facilities giving extended care in anticipation of private facilities to provide non-urgent care.

The sole purpose of the Vancouver Island Health Authority is meeting the budget. The only way they can see to achieve this is to cut health care. While they continue to squeeze and choke the life out of our health care system, they continue to develop positions in management to attempt to gain more control over it. As a result, health care monies are transferred from the actual helping of people to the management of the system, and costs continue to rise, while health care declines.
The effective delivery of health care services can be enhanced if it takes into account local community concerns and insights on how best to meet that community's health needs. The Southern Gulf Islands Community Health Advisory Committee provides an example of a representative community consultation model that provides for local engagement in health planning for Gulf Island communities.

There are substantial differences in standards of health care delivery between the Fraser Health Authority (mediocre to poor) and Vancouver Coastal Health (good). Vancouver Coastal Health tends to be much better in terms of speed of access, shorter wait times for diagnostics and treatment or emergency services, better access to general practitioners and so on.

The Interior Health Authority’s decisions are not based on any realistic evaluation of its constituents. They have ignored the community and set an authoritarian standard which is insensitive to the community’s opinions.

Interior Health will not listen to the people of the West Kootenays.

The Chief Executive Officer of the Fraser Health Authority had plans as to how to alleviate the problem with the influx of new patients. Now he is gone and it will take someone with the same speed and determination to address the problems as he did.

Interior Health Authority employees act as advocates with a blatant bias.

The inability to recruit a Chief Executive Officer for Fraser Health is a very tangible example of the difficulties that arise when one micro-manages.

The Interior Health Authority region is too big. Face-to-face meetings are very difficult and expensive.

Since the amalgamation of the North Shore and Vancouver Regions, the opportunity for input from North Shore residents has been minimal. The region is too large. The interests of the two are not always similar and the distance to attend board meetings is unreasonable.

In Vernon, the operating rooms are closed for more hours than they are open. We have huge numbers of highly paid administrators and rooms that once had beds in them are now used for offices.

The Vancouver Island Health Authority prioritizes the three C’s (cancer, children and coronary) and does a good job on these. Why not rationalize the rest of the services in the same way?

Fraser Health has started on the right foot, adopting a collaborative, multidisciplinary approach to clinical service planning through its Acute Care
Capacity Initiative (ACCI) and it has begun a comprehensive process to understand its current state and study its potential future directions. Fraser Health has also approached this organizational change incrementally; a transitional structure is appearing as evidenced by its recently formed Council of Surgical Chiefs.

Ideas and Suggestions

General
Specific Health Authorities, Services or Facilities

• General ideas about health authorities, services and facilities:
  • Have a round-table with front-line staff.
  • Cultures of success take time to build. Every time you restructure or make another Chief Executive Officer move on, you disrupt that culture and put the organization back to square one. Seek ten to 20 year terms for Chief Executive Officers and find principled people who love a challenge and keep finding new ones every year, while they stay in their job for ten years and build a healthy culture. Right now health care is one of the unhealthiest places to work. Let us change that!
  • Make health authorities transparent. Ensure that all reports are made public.
  • The head of administration preferably should be a physician trained in administration.
  • No more money should be spent on the administrative side of the health care system.
  • Reduce the size of the health authorities and give facilities more autonomy so that they regain ownership and pride.
  • Create 15 health authorities (one for each geographic region in the province) which will be totally accountable, directly elected (every two to three years), and fully transparent to the electorate.
  • Implement community advisory bodies.
  • Consider smaller health authorities, or creating community bodies that report to health authorities.
  • Eliminate health authority boards and create elected boards.
  • Ensure health authority boards have a cross-section of talent and interests represented.
• Do not focus entirely on the bottom line.
• Undertake a review of the health authority model.
• Constantly evaluate the effectiveness of health authorities through clear performance measurement.
• Services should be managed province-wide.
• Create an independent health authority ombudsman.
• Elect front-line worker representatives, First Nations representatives and local community representatives to health authority boards.
• Improve communication with people within the regions and communities.
• Plans need to be made for the next 15 years. Think of the future.
• Consolidate and centralize management functions.
• Shake up upper management at health authorities. The only way to initiate a change is to start at the top. Hire someone with new ideas and someone who is willing to treat their staff with the dignity and respect they deserve. Hire someone from the outside who has not worked in health care but is a real go-getter and make it better.
• The hierarchy in the regions should be investigated, as it has become very top heavy in the last ten years. While workload on the wards becomes extremely heavy, more and more managers are hired.
• There must be a reorganization of the health authorities. They are all top heavy in administration. Highly paid staff members are replacing the old hospital boards that ran primarily on volunteers, and did a much more efficient job of keeping a hospital running in good order. Health authority administration requires expensive offices, vehicles, and many other perks that cost the system plenty.
• Improve the relationship with the unions, as too much time and money is currently wasted on this relationship.
• Communities should have a fair and efficient process for resolving differences with their health authority, including internal review and an independent external review process system.
• All health authorities need to be evaluated by an outside, independent body.
• The budget to each health authority should have a percentage factor set up that administration costs shall not exceed. This would then create more flow of budgeted amounts to the needs of the people rather than to the creation of an
extremely large bureaucratic jungle that sucks up budgets like a huge sponge and delays any immediate reaction to problems.

• Rid the system of unions: get pride back in the workers and build self-esteem.

• A return to administrators running hospitals and nursing homes would be a step in the right direction. We need people with health backgrounds organizing health care.

• Ensure that professional and patient advisory councils have a far greater say in regional health care policies.

• Identify those health authorities under stress and direct the necessary resources to meet their specific targets and then publicize the specific progress made on all targets regularly on a regional basis.

• Let the north east of British Columbia control its own health care. This will allow us local control of our own lives, and respect and dignity for our seniors.

• We should elect public advocates.

• **Specific ideas for health authorities, services and facilities:**
  
  • We need better co-ordination between the Northern Health Authority and community service providers.

  • In order to give rural health care a working chance, the government needs to revamp the way health authorities are structured. The Interior Health Authority's Kootenay Boundary regional structure has not been working.

  • Eliminate Interior Health and bring back the hospital board.

  • Helping others to receive improved surgical services from Fraser Health can be a unifying cause for our surgeons and other health professionals across Fraser Health. Designing a model that increases access to underutilized surgical capacity, with the surgeons and other key stakeholder participating in the design, allows culture and mission to shape the organizations strategy and increases the long-term fit between culture and strategic directions.

  • Fraser Health should make its best efforts to assess the impact to specific patient and community wait lists, specific surgeons and sites and target these sites and surgeons for catch-up by means of pilots, one-time infusions and other transitional plans. For example, these surgeons might be offered opportunities to access the additional capacity at another site.

  • Fraser Health should identify those changes that it can initiate immediately and move forward on making the necessary changes in order to create momentum and reengage the physicians and surgeons.
Fraser Health should develop a set of guiding principles for physician transitions and a comprehensive transition model including the pre-negotiation of any stakeholder and third party participation. Providing evidence of new approaches to transition should be advanced incrementally through models and pilot projects. This allows for selected targets, models to be fine tuned and physician leaders to contribute and advocate based on recent, positive experience.