Governance and Accountability in Health Services Delivery:

A Submission to BC Conversations on Healthcare

"We live now in an era of great public expectations around accountability and transparency for performance and the wise use of public funds. If we are to endorse the public administration of health services, then we need a higher measure of public accountability for performance. In the private sector, as well, where shareholder interests are concerned, much higher degrees of transparency and accurate public reporting are expected today."

Bob Rae,
Canada in the Balance, page 84
McClelland & Stewart Ltd. 2006

"Subsidiarity is the principle that government works best – most responsibly and responsively – when it is closest to the people it serves and the needs it addresses. Fiscal accountability is the principle that institutions collecting and disbursing taxes work most responsibly when they are transparent to those providing the money."

Jane Jacobs
DARK AGE AHEAD, page 103
Vintage Canada 2005

Tim Lynch
Health Services Reimbursement Consultant
Info-Lynk Consulting, Vancouver
Tel. 604.916.9302
Email: tim@infolynk.ca

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Abstract: The Honourable Gordon Campbell, Premier of British Columbia, is to be congratulated on initiating these Conversations on Healthcare. They give British Columbians the opportunity to become informed about health issues between elections. This submission is based on an analysis of conversations about healthcare held with British Columbians in communities around the BC Lower Mainland just prior to the 2004 federal election. It reviews some of the issues related to federal / provincial roles and responsibilities as well as governance oversight in healthcare. The way governance is evolving in the BC Health Authority structure is assessed against this background. The recent departure of Health Authority Board Chairs at Vancouver Coastal and Fraser Health Authorities and the earlier sudden departure of the Deputy Minister of Health as well as other executive replacements within the BC health system may be symptomatic of problems in defining roles and responsibilities between the Ministry of Health and the providers of care. With the emergence of professional health administrators in provider organizations and the central funding agencies, and the increasing development of population based E-health organizations, the traditional role of health governors, besides possibly their fundraising duties, may be becoming redundant. A modern role for health governors could be to serve as intermediaries protecting the health system from politicians, who on certain days, micro-management local crises. The BC Ferries Corporation serves as such a governance model developed in BC. This trend in healthcare governance is evolving in the UK's National Health Service (NHS) with the introduction of Public Benefits Corporations. If they are to become relevant in a professionally managed health system the rules of engagement between health governors and their political masters need to be well understood.

Governance and Accountability in Health Services Delivery

A Submission to the BC Conversations on Healthcare

The Honourable Gordon Campbell, Premier of British Columbia, is to be congratulated in initiating these Conversations on Health. Compared with the traditional way of developing health policy by commissioning an elder statesman, or eminent provincial academic, the BC Conversations on Health is a breath of fresh air.[i] With its forums, website, newsletter, and on line discussion groups, an open structure has been created that supports a transparent and well resourced initiative. With the process and structure in place we can now look forward to outcomes that should be responsive to health consumers and providers in British Columbia.

About this Submission

This submission is based on an analysis of conversations held in communities around the BC Lower Mainland just prior to the 2004 federal election. These conversations occurred in a series of political party meetings where healthcare was constantly raised as an issue of concern. Being knowledgeable about Canadian healthcare, I was frequently asked to provide an explanation. Attempting to engage in such conversations was problematic when the explanation did not support "conventional wisdom." The tendency was to back-off and refrain from expressing an opinion. However, the opportunity to explain to people seeking political office how they related to healthcare was challenging.

A review of conversations held during this period evolved into a workshop designed for people seeking political office at the federal, provincial or health board level. It begins with analyzing the role of the electorate as taxpayers, questions oversight, considers political versus public administration accountability, assesses federal / provincial relationships, looks at private and public insurance, reviews quality of care and explores the role of business in a public health system. The complete session can be viewed at http://www.infolynk.ca/governance.html

The line of inquiry made during this period focussed on governance and accountability. This submission will outline some of the issues raised and relate them to BC's Health Authority governance structure.

The Continuous Nature of Healthcare Conversations

The experience derived from this exercise suggests that healthcare conversations should be continuous. People's opinions and suggestions for solutions are different. Some want decisions made for them and to be given directions. Others want to be involved in decision-making and to have their options acknowledged. There are always more questions than answers. For this reason this analysis resulted in a questionnaire that lists some of the areas where further consultation and guidance is required, see Appendix 1. Consideration should be given to developing some structure, possibly the

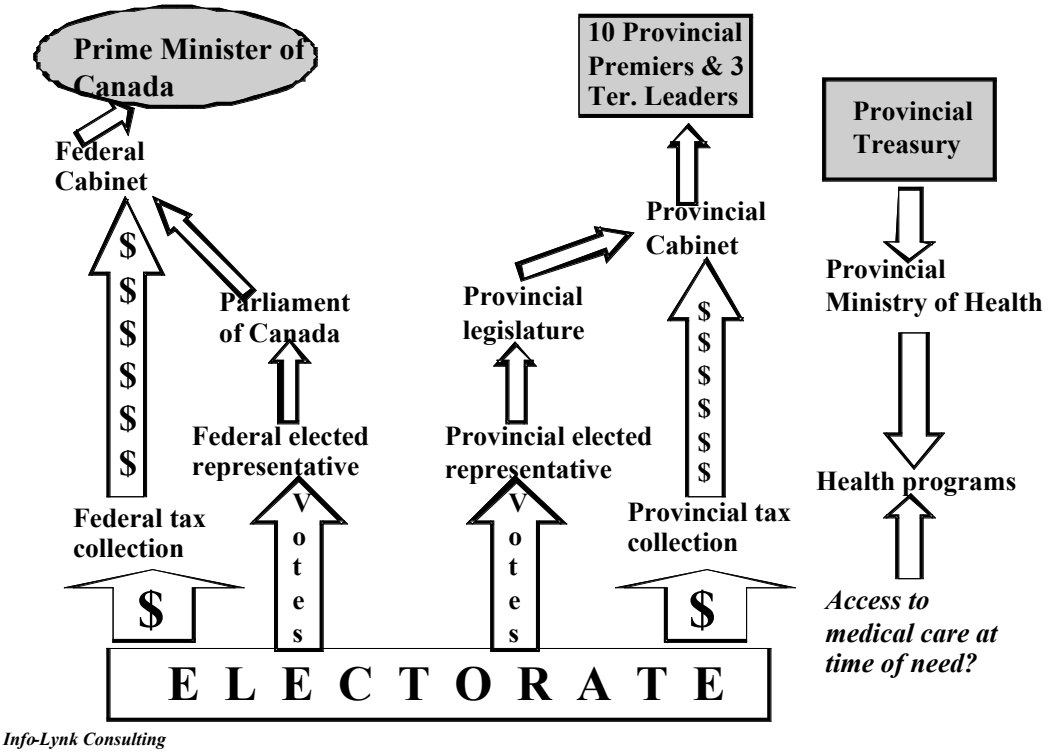
continuation of the website, to a continuous public discussion on healthcare beyond the BC Healthcare Conversations initiative.

Federal Provincial Relationships

The period just prior to elections, be they federal or provincial, is not the best time to discuss health policy. The conflicting and misinformed viewpoints expressed about healthcare by competing politicians create a great deal of anxiety in the general public, leaving people perplexed, bewildered, confused and frightened. Furthermore follow-up media commentary usually adds to the confusion.

Conversations on healthcare held during the period leading up to the 2004 federal election, provided a national perspective of health issues. Figure 1 is part of a series of exhibits that illustrate relationships among the electorate, both levels of government and health programs.

Figure 1: Federal/Provincial Tax Collection and Dissemination for Health Services



The image of two columns with arrows pointing up and one with arrows pointing down was most prominent. The electorate was seen as having two roles: (1) elect their representatives (2) pay taxes. It was acknowledged that the power lies with cabinet around tax collection and spending. How the Prime Minister related to the provincial and territorial leaders was not clear, other than that it was more often a fractious relationship than a constructive one, and it depended on how insecure politicians are in their relationship with their electorate. To see how accountability changes from federal to provincial to professional go to agenda item 1 on the workshop website.

There was general agreement that the amounts of money distributed from the federal treasury to the provincial and territorial treasuries had more to do with negotiating tactics and the likelihood of winning the next election rather than serving health needs. The lack of responsiveness in identifying waiting lists earlier, and allocating money accordingly was frequently identified as an example of failure at both levels of government to equitably support taxpayers in need.

Figure 1 shows that both levels of government tax the electorate with the amount spent on health coming from the provincial treasury. There is confusion about the accountability of the federal government for supplementing provincial health budgets. There were conversations about what dictates the amount of money allocated by provincial treasuries for health services beyond funding established programs.

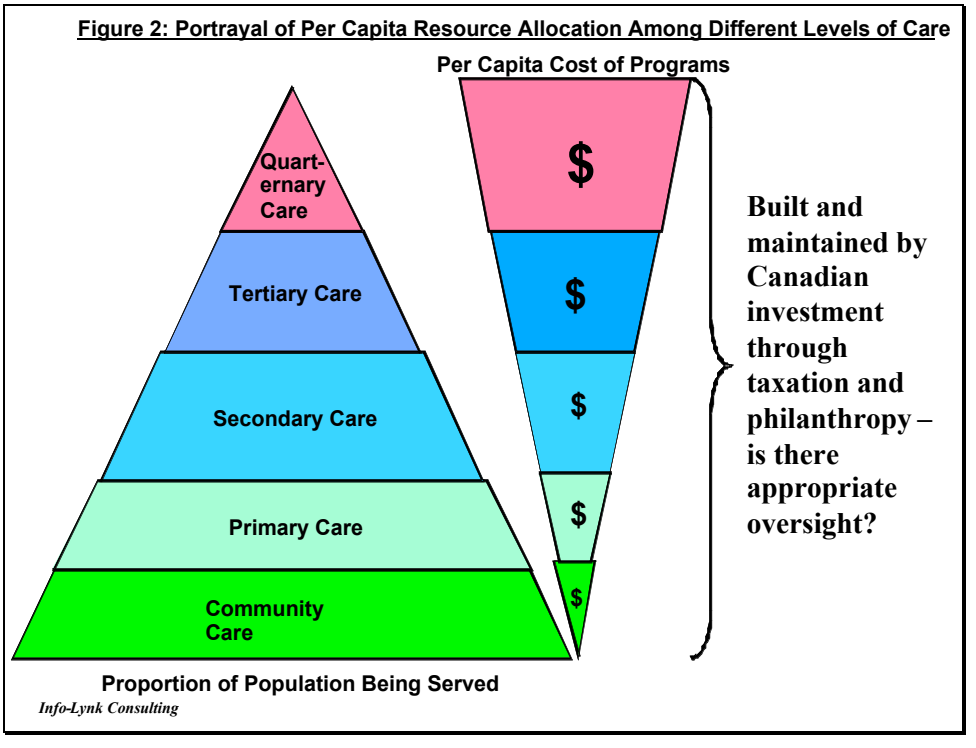
The role of the Ministry of Health in the transfer of funds to provincial programs is not clearly understood. The primary confusion arises in understanding the point at which health funding ceases to be allocated on the basis of political rationales, and is professionally managed. [ii]

Healthcare Oversight

Who is looking after the store and are they suitably qualified? This was one of the questions raised, directly or indirectly, during several conversations on healthcare that were held just prior to the 2004 election. Figure 2 evolved as a means of providing a frame of reference for discussing oversight of healthcare resource allocation. The intent is to show how, on a per capita basis, hospital care is more expensive than community care; see item 2 of the workshop.

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.

Figure 2 is particularly relevant in the context of health services oversight in BC. The 2002 Health Authorities Act of British Columbia provided a legal framework for the BC 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, as portrayed in Figure 2.



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 achieving the outcomes dictated by their Board. Within this paradigm it is the Board to whom the CEO reports and that hires and fires the CEO. A conversation question was: Is this the point of transition from political accountability to when a more professional accountability occurs?

Collegial relationships have evolved between the professionals who administer health programs and those who work in Health Ministries. Frequently careers transcend both worlds. A trend over the past decade has been the lateral movement of private sector executives into health leadership positions. Another significant trend in health administration over the past two decades has been the application of evidence-based best practices methodologies, both in clinical practice and administration. These methodologies serve to evaluate decisions being made and provide guidance on making more appropriate decisions in real time. Three year performance agreements between health authorities and the Ministry outline: expectations for the delivery of patient services, health outcomes and health care spending, while providing flexibility and autonomy to meet regional needs. Do these kinds of agreements constitute more of a technocratic approach towards health governance thereby making governors irrelevant?

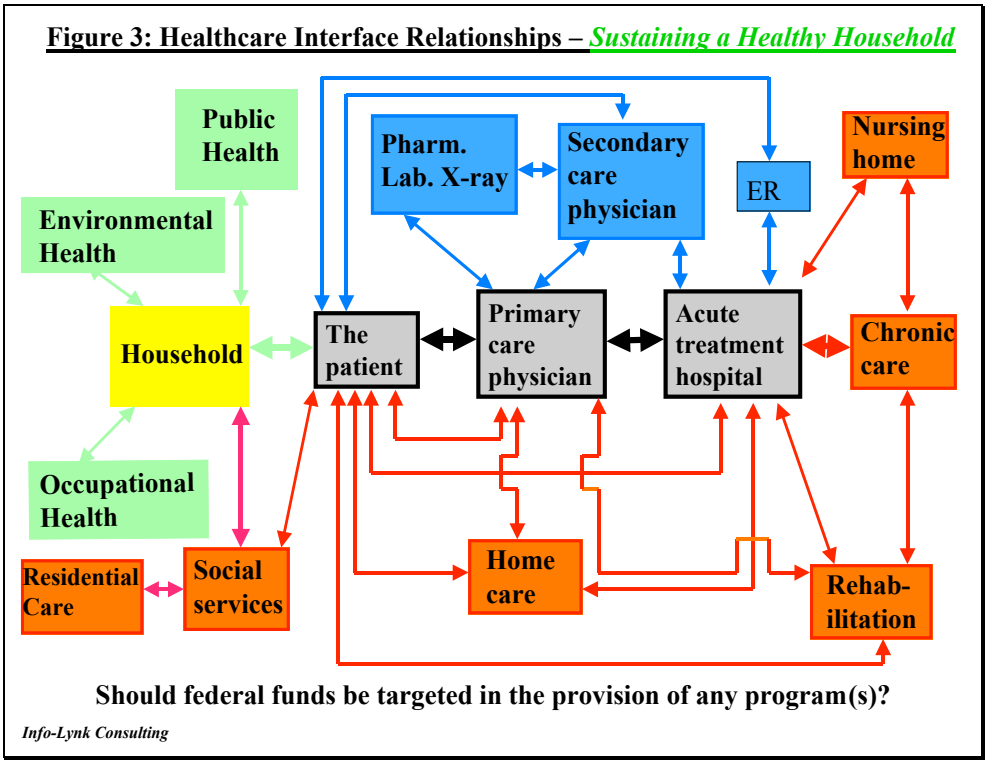
BC was recognised as having independent centres of excellence through societies dedicated to the development of tertiary / quaternary care teaching hospitals as well as speciality institutions like: BC Cancer Agency (BCCA), BC Transplant Society (BCTS), BC Centre for Excellence in HIV/AIDS, BC Centre for Disease Control (BCCDC) and the Kidney Disease Services (KDS). Under the Health Authorities Act of British Columbia these organizations, with the exception of the BC Centre for Excellence in HIV/AIDS for some reason, have been amalgamated under the Provincial Health Services Authority (PHSA). The board of the PHSA is expected to provide oversight of areas of scientific advancement that were governed by individual boards serving highly specialized scientific societies. This responsibility has to be a daunting task for PHSA Board members. Centralization of core administration services is seen as the rationale for this structure. Does the PHSA serve an administrative function more than a governance function?

Federal Provincial Responsibilities

During the 2004 federal election there were frequent conversations about the federal government being involved in funding home care or possibly pharmacare, and a lot of commentary about the federal government funding such acute care services as hip and knee replacements. Figure 3 is the composite result of a series of slides displayed in workshop agenda item 4 showing healthcare interface relationships and federal / provincial responsibilities, each colour representing different phases in service requirements. BC is the only province in Canada that has integrated all of the health and social services shown in Figure 3 under on one governing board through its 2002 Health Authorities Act.

Figure 3 serves to demonstrate how the federal government, though the Canada Health Act (CHA) influences the relationship between patients and their need for access to physicians, diagnostic services, and in-patient hospital care (the central gray boxes.) Under the portability clause of the CHA any Canadian in any part of Canada is entitled to access medical services without having to consider cost implications provided they can show a valid provincial health card. Provincial policies seen to be limiting this access could result in the federal government withholding funds under CHA fiscal transfer arrangements, as has been the case in BC.

Each of the provinces has programs that are similar to the ones named in the boxes in Figure 3. 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 CHA only guarantees Canadians access to medical, diagnostic and inpatient hospital services.



The concept of a sustainable healthy household evolved by way of differentiating between "Health Care" and "Sick Care." True "Health Care" is comprised of programs supporting the healthy household such as Public Health, Environmental Health and Occupational Health. All other programs belong to the "Sick Care" system supporting people who are classified as "patients." Within its population health based strategy BC is a leader in recognizing the complementary nature of "health care" relative to "sick care."

Figure 3 provides an illustration of an E-health model of healthcare that efficiently shares information among professionals, consumers, and stakeholders. As the technology improves, in a truly E-health management model the system can be monitored and a high degree of decision making accountability established. Furthermore, as population health based strategies assume greater prominence in systems design, guidance of the system could become more automatic, thereby making governors that much more redundant.

The Role of Business in Healthcare

Conversations about the role of business in Canadian healthcare usually devolve into ideological debates. Figure 4, the concluding slide to the workshop, attempts to resolve this problem by inventing a new word "Co-optation," a combination of the words competition and cooperation.

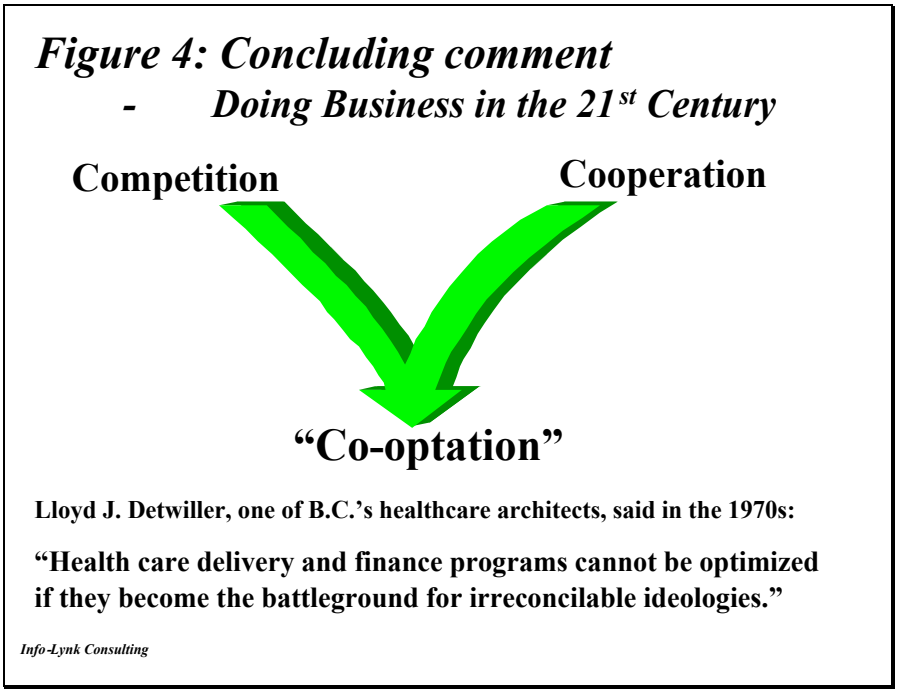


Figure 4 also acknowledge the prophetic statement made by Lloyd J. Detwiller, one of B.C.'s healthcare architects, in the 1970s. Indicative of the dilemma in defining the role of business in providing health services, the questionnaire in Appendix 1 asks three questions about the role of business in healthcare:

> Are business leaders optimally involved in healthcare decision-making?
> Should health be subject to the same accountability as business?
> How dependent is health policy formulation on an understanding of public finance and business ethics among political leadership?

Long before government was involved in the healthcare business people gathered within their communities to form not-for-profit corporations or societies in support of developing hospitals and other healthcare programs in their communities. Within our publicly funded health system successful business people continue to be relied upon to donate their wealth and expertise in support of hospital wings and healthcare programs.

Evidently there is the 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, etc. 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.

Many people chosen to serve as health authority governors in BC are entrepreneurs. In their routine occupations business people make decisions that involve spending their own money. This insight and experience is expected to give business people more objectivity to public servants in assessing if resources are being allocated in the public interest. This is the governance oversight business people are expected to bring to the table. How relevant is this governance oversight within the confines of Health Ministry guidelines and directives?

Concluding comment

There does not seem to be any emphasis in BC Health Conversations to discuss "Governance and Accountability." This suggests that such concepts are "givens" and that the Conversations are restricted to service delivery. If this is so, the resulting product is in danger of becoming a stack of cards on a layer of sand that is threatened by liquefaction at the next tectonic shift in the political imbroglio that is BC.

There have been a number of incidents recently suggesting that the governance of the BC health system is experiencing some turmoil. The sudden departure of Health Authority Board Chairs at Vancouver Coastal and Fraser Health Authorities and the earlier departure of the Deputy Minister of Health may be symptomatic of problems between the Ministry of Health and its Health Authorities.

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.

Perhaps a more useful role for modern health governors would to protect the health system from politicians trying to micro-manage local crises on a daily basis. In BC these days are referred to as a Deputy Minister's "bad hair" days.[iii] Such rules of engagement exist in BC with the relationship of BC Ferries Corporation to the BC government. Perhaps the best way of managing BC's health system is by forming a similar professionally managed "BC Health Corporation" with an independent board. The challenge with such an entity is that it would be responsible for supervising the allocation of close to 40% of the provincial budget thereby, denying politicians credit for decisions being made of the use of tax money they are expected to be accountable for.

One European model the Premier may consider is the kind of health governance model evolving in the UK. In a presentation given at the Vancouver Board of Trade's Health Forum, February 6, 2007, Mark Britnell, South Central National Health Service (NHS) Strategic Authority, indicated that the UK's NHS is gradually adopting this form of "Public Benefits Corporation" governance by emulating such models as the Bank of England, the BBC, the Judiciary, etc., in order to reduce political interference in health services delivery.

Conversations about strengths and weaknesses of public health administration in BC should be a source of intellectual fervour among health managers. In reality, engaging BC health managers at all levels in conversations about publicly funded healthcare frequently results in messages of insecurity. The defence for this response is that they have witnessed so much upheaval in their roles under different political regimes over the past few decades they are not sure of their job functions. Sustaining professional enthusiasm is critical if the system is to confront the healthcare challenges in BC. A lack of enthusiasm can place a strain on leaders in the boardroom, and at executive and program levels. This will ultimately, influence recruitment of credible volunteer board members and professional staff.

In his 2006 book "Canada in Balance," Bob Rae, former Premier of Ontario and Liberal Leadership Candidate articulated the sentiment expressed in the conversations I witnessed during the period leading up to the 2004 federal election where he states on page 84:

> "We live now in an era of great public expectations around accountability and transparency for performance and the wise use of public funds. If we are to endorse the public administration of health services, then we need a higher measure of public accountability for performance. In the private sector, as well, where shareholder interests are concerned, much higher degrees of transparency and accurate public reporting are expected today."

Accepting that the shareholders of Canada's public health system are the Canadian taxpayers, the analysis of healthcare conversations held in the BC Lower Mainland just prior to the 2004 elections emphasizes the need for shareholder accountability in the delivery of public health services in British Columbia and Canada.

Five questions

Not surprisingly, given comments made earlier about the "Continuous Health Conversations," relating the experience of the serendipitous healthcare conversations held during the run up to the 2004 federal elections with the more strategically organized BC Healthcare Conversations process, has resulted in the following five questions:

> Given that the BC government needs a legal framework in order to fund and organize its health services as well as to establish a framework for retaining the services of independent physicians within its health system, what other purposes do health authority board members perform?
>
> Is the hiring of the CEO by the Health Authority Board the point at which political accountability ceases and independent professional public administration accountability begins?
>
> To what degree are Health Authority board members expected to provide an advocacy function and are they expected to be accountable to the public?

Does the Provincial Health Services Authority (PHSA) serve an administrative function more than a governance function?

Should rules of engagement between Health Authority Board members and politicians be constituted in order to ensure a governance structure that will verify some degree of continuity in patient care above and beyond daily political crises and the need for elections?

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[i] Tim Lynch, The Romanow Commission: An Opportunity Lost, Hospital Quarterly, Winter 2003 http://www.infolynk.ca/romanow.html

[ii] In her book DARK AGE AHEAD, Jane Jacobs states, "by agreement, the sovereign federal government (of Canada) and the provinces are supposed to share the cost of health and hospital services. But a curious thing happens. When the federal government grants additional funds to the provinces to be disbursed for that purpose, our province (Ontario) along with some others, has been deducting an equivalent from their own contributions, raised from their own taxes. Neither the federal government nor citizens have been able to learn what provincial kleptocracies do with these downfalls." Page 110

[iii] Dr. Penny Ballem, former BC Deputy Minister of Health, discusses the need for effective crisis management at the Breakfast with the Chiefs Forum, Toronto, December 15, 2006.

APPENDIX 1: Governance and Accountability in Health Services Delivery: *A Primer on Health Care for Canadians Seeking Political Office and New Healthcare Governors*[1]

Workshop Participant Opinion Survey

Note: The responses listed below each question are intended to provoke individual thought and subsequent group discussion. Before starting the workshop mark an X showing you support for each of the responses. Leave blank if not sure. When each section is completed circle the number identifying your degree of support for each response in that section. Add statement(s) if you think they describe better your interpretation of the question being considered.

	Disagree			Agree
1) Are federal and provincial governments and healthcare governors accountable to the electorate?				
a) Federal and provincial governments are held accountable at elections	1	2	3	4
b) Trustee accountability depends on whether they were elected, selected or appointed	1	2	3	4
c) Health trustees are the instruments of the provincial government	1	2	3	4
d) Health trustees serve as advocates for the communities they represent	1	2	3	4
Other…….				
2) Are doctors' services always worth paying for?				
a) Doctors' billing practices are not influenced by their self interests	1	2	3	4
b) Fraudulent behaviour by doctors is insignificant and not worth recovering	1	2	3	4
c) Provincial billing systems do not reward excellence in medical practice	1	2	3	4
d) Provincial Medical Associations serve to preserve the status quo	1	2	3	4
Other……..				
3) Is there sufficient oversight in health services delivery?				
a) The federal government allocates a negotiated settlement with no accountability	1	2	3	4
b) Provincial governments transfer accountability to the health trustee governance infrastructure	1	2	3	4
c) Targeted criteria are required to demonstrate accountability	1	2	3	4
d) Other…….				

[1] An embedded health policy analyst in the trenches of Canadian political warfare in BC during the 2004 federal election developed this questionnaire as part of a workshop that attempts to address queries made by local candidates and politicians during the election.

	Disagree			Agree
4) Should there be provincial health outcome comparisons?				
a) For waiting lists only	1	2	3	4
b) For specific diseases such as cancer, cardiovascular, etc. only	1	2	3	4
c) For general provincial population health status indicators	1	2	3	4
d) Other……				
5) Where is the political accountability in health care?				
a) Government is accountable for providing access to medical care at time of need	1	2	3	4
b) Government is accountable for making health services available to all Canadians	1	2	3	4
c) Both federal and provincial governments are equally accountable	1	2	3	4
d) Health trustees should be held more accountable for oversight of the system	1	2	3	4
e) Other……..				
6) Should federal funds be program specific?				
a) Only for home care programs	1	2	3	4
b) Only for pharmacare programs	1	2	3	4
c) Only for rehabilitation programs	1	2	3	4
d) It is not possible in the context of federal transfer payments to provinces	1	2	3	4
e) It would be a form of interference in provincial affairs	1	2	3	4
f) Other……...				
7) Should federal funds be linked to provincial health services integration?				
a) Provincial health services integration is no business of the federal government	1	2	3	4
b) Provincial health services integration should be rewarded	1	2	3	4
c) Autonomy of healthcare institutions is critical to quality of care & fund raising drives	1	2	3	4
e) Cultural differences among health programs makes full integration impossible	1	2	3	4
f) Other…….				

	Disagree			Agree
8) How is accountability for appropriate use of prescription medicine shared among pharmaceutical companies, prescribing physicians, pharmacists and patients?				
a) The prescribing physicians are totally responsible for use of medicines they prescribe	1	2	3	4
b) Patients should pay for medicines that they do not use appropriately	1	2	3	4
c) Pharmacists are responsible for advising patients on the use of prescription medicines	1	2	3	4
d) Pharmaceutical companies have a responsibility to educate physicians and patients	1	2	3	4
e) Government is responsible to ensure the appropriate use of prescription medicines it pays for	1	2	3	4
f) Other…….				
9) What is an acceptable level of quality in health care for Canadians?				
a) Ease of access / shorter waiting lists / attentive professional and support staff	1	2	3	4
b) Publication of morbidity (sickness) / mortality data at regional / institutional level	1	2	3	4
c) Achieving provincially targeted health status indicators	1	2	3	4
d) Maintenance of Canadian Council of Health Services Accreditation Standards	1	2	3	4
e) Other…….				
10) Should federal government regulate private health insurance?				
a) Health insurance (public & private) is a provincial responsibility	1	2	3	4
b) Yes with respect to ensuring portability coverage in Canada and abroad	1	2	3	4
c) Possibly in coordination with provincial WCB and other rehabilitation programs	1	2	3	4
d) Only when private insurance companies take advantage of limitations in public system	1	2	3	4
e) To encourage symbiotic relationships between the public and private insurance systems	1	2	3	4
f) Other…….				
11) Are business leaders optimally involved in health care decision-making?				
a) Business people cannot appreciate decision-making by health professionals	1	2	3	4
b) Business representation should only be used to support fund raising	1	2	3	4
c) Business people are needed to ensure accountability of public expenditures	1	2	3	4

	Disagree			Agree
Question 11 continued				
d) Professional health administrators do not need business people overlooking their work	1	2	3	4
e) Business people are more inclined to have conflicts of interest than non-business people	1	2	3	4
f) Academics provide better quality input than business people	1	2	3	4
g) Other……				

12) Should health be subject to the same accountability as business?

a) Public health care cannot be subjected to the same kinds of accountability as business	1	2	3	4
b) Health administration has a lot to learn about accountability from business	1	2	3	4
c) Health programs should be managed like business	1	2	3	4
d) All health programs should publish annual financial statements as required in publicly traded companies	1	2	3	4
d) Other……				

13) How dependent is health policy formulation on an understanding of public finance and business ethics among political leadership?

a) Business ethical practices and public ethical practices are synonymous	1	2	3	4
b) There is no such thing as "business ethics" in the ideological world of politics.	1	2	3	4
c) Politicians should serve their constituencies and not be too concerned with business	1	2	3	4
d) Private financial management cannot be compared with public financial management	1	2	3	4
e) As more business people enter into public service as politicians there will be greater opportunity for instituting business ethics in public finance	1	2	3	4
f) Policy formulation is initiated by voter concerns more than business practices	1	2	3	4
g) Other……..				

To receive analysis of your interpretation to this survey relative to other participants fill in the following information.

Name _____ Affiliation (optional)_____

Email _____ Tel. _____ Date _____

Inquiries about this survey should be directed to Tim Lynch, Info-Lynk Consulting: 604.916.9302 Email tim@infolynk.ca