NEWFOUNDLAND
AND LABRADOR
HEALTH
BOARDS
ASSOCIATION

RESPONSE TO SPECIAL REVIEW REPORT (J. ABBOT)

NLHBA Mailing Address
P.O. Box 8234
St. John's, NF
A1B 3N4

NLHBA Delivery Address
Beclin Building
1118 Topsail Road
Mount Pearl, NF
A1N 2M3

Telephone (709)364-7701
Facsimile (709)364-6460
Email nlhba@nlhba.nf.ca
Web Site www.nlhba.nf.ca

August 25, 2000

1 Introduction

The Newfoundland and Labrador Health Boards Association has now had the opportunity to review the Preliminary Provincial Overview Report (the Report). The Health Boards have provided the Special Review Team with their detailed comments with further interpretation and clarification to data and commentary on each Board's operations appearing in the preliminary version of the Report. This review will therefore be confined to concerns and comments on the Report that are relevant to the system as a whole. These remarks reflect consultation with our members and represent a broad consensus on the issues discussed.

The Association would like to congratulate the Special Review Team on the enormous amount of work completed within the time constraints, and the valuable data gathered as a result.

2 Mandate of the Special Review Team

The Association is concerned that the interpretation of the mandate of the Special Review Team may have changed since the Minister of Health and Community Services spoke to the Board of the Association after the unveiling of Budget 2000. At that time, the Health Boards understood that the review would determine the costs of providing the mandated services at the required level, and whether the Province could continue to afford those costs. If the answer were to be negative, then decisions would be made at the Department level on which services to discontinue. The Minister gave it as his opinion that there would likely be only minor efficiencies that could be undertaken in the health system as the result of this review, and that there would need to be some difficult decisions to consider.

The Report, however, seems to be addressing another question, namely "Given that we only have this amount of money, how can we manage to provide the mandated services?" This is a question that has been answered by every review that has been done to date and by the day-to-day experience of the Health Boards. It is not possible to provide the mandated services to the level required, even with outdated or non-existent standards, with the current level of funding. Is the service mandate or the funding changing? That is what the Health Boards need to know.

To facilitate this process, the Association recommends, at the outset of the Report, a comprehensive review of the services mandated in order to present a full picture of the basis for institutional operations of Health Boards.

3 Overview

3.1 Choice of Base Year

The Report would benefit from providing a rationale for the choice of one particular year, 1996/7. It may well be that this year was chosen for a particular purpose as a relevant or convenient comparison year on the grounds that costs increased sharply after that time.

However, there are concerns with the use of a single year as a point of reference when it is not clear why that year represents an acceptable and valid standard and what merit there is in the comparison. Is there an assumption that the health system in 1996/7 was provided with adequate funding to fulfill its mandate from government and meet the needs of the population? There is no assessment of other factors in that year or following years that affect the health system, such as demographic change, so it is hard to assess what has been learned from this comparison when Health Boards feel that the mandated services were not appropriately funded in the comparison year. In addition, events affecting funding in the comparison year may have been atypical for any particular Health Board or even for the entire institutional system and therefore would not be a valid starting point for investigation.

3.2 Budgeting Process and Global Funding

The review of the Boards' concerns in 5.2 *Board and Department Budgeting Practices* covered many of the issues that the Association on behalf of the Health Boards has brought to the attention of the Government over the past years. The comparison with the Manitoba report also reiterated many of the same concerns highlighted by Health Boards in this Province. The Association has not been alone in calling for strategic planning by the provincial Government and the Department of Health and Community Services to establish the responsibilities and roles of all parties in the health system, including Government departments involved. The provincial Auditor General, in the annual Auditor General Report, has also pointed to the importance of strategic planning to facilitate accountability in the province.

However, on turning to the team's "suggested approach," the statement that "global budgeting will not be effective for the Province's health system" does not make a positive and insightful contribution to the budget process in the health system in the Province and requires further consideration. There is no evidence provided on which this decision is based nor is there any recognition of the wide-reaching implications of such a statement. Indeed, the Association has been lobbying for the requisite technology, system-wide standards, strategic goals and timely Government responses to budget proposals which will enable the global funding system to gather the evidence required for evidence-based decision making to achieve its potential and function smoothly. No one is in favour of the patchwork of information resulting from the current absence of clear system-wide guidelines and appropriate technology for gathering and reporting information.

In the early 1980s hospital budgets were monitored on a line-by-line basis in the health system. This necessitated teams of people spending several days on site to examine budgets and engage in sometimes acrimonious discussion on budget issues and choice of funded services. A great deal of time and money was spent in this manner. Operational

decisions were approved by Government and Government was therefore responsible for the results of those decisions.

Global budgeting was installed in 1982 in order to address these problems, to make the people on site responsible for their own budgets and to remove the government from the day-to-day operations of the health system. No deficits were funded, 50% of any surplus was retained by the Board and service priorities were decided at board level according to the circumstances of the region. Because Boards made operational decisions, Boards took responsibility for successes and challenges arising from those decisions.

Global budgeting was therefore in existence before reform and it worked relatively well. Reporting requirements used to be much more stringent, with two Annual Returns required, in standard format, with analyses of financial and statistical information. As a side benefit, the Royal Commission on Hospitals and Nursing Homes was able to draw on a large data bank of statistical information that had been collected in a uniform manner in previous years. Unfortunately, the Report has been hampered by the lack of such information-gathering and reporting standards and seems to have accepted the Treasury Board view that this is the result of global budgeting. In fact, since the institutional boards were set up in their current form, their operations have been considerably complicated by these structural deficits. If standards and expectations had been established simultaneously with the new institutional Boards and appropriate technology installed and funded, the health system in the province would by now have good evidence on which to base health decisions. In the absence of clear system-wide standards, Health Boards have had to implement their own methods, which are not necessarily compatible with other Boards in the system, but which fit the available budget room for that individual Board. As an example, Meditech was approved in 1983, presumably to standardize the gathering and reporting of data, but, as mentioned in the Report, has still not been fully implemented by all Health Boards due to lack of dedicated funding for this purpose. Although Meditech has been modified, developments in the health system realistically call for a universally installed (Health Boards and Government) modern information system. The Health Boards are aware that there may

be funding forthcoming for information technology in the health system and look forward to a universally valid data collection and monitoring system that will be an important tool in accountability and communication, internal and external, and enable the global budgeting system to function smoothly.

A timely budget process is an essential requirement for the health system to function smoothly. The Association has been lobbying the Government for an accountability framework that includes such a process and clearly defines the roles and responsibilities, not just of the Health Boards but of Government as well. At this point, Government has drafted a process that defines the roles of Health Boards but is almost silent on requirements for its own responsibilities. The Department of Health and Community Services and Treasury Board need to develop clear guidelines in consultation with Health Boards, for a budget reporting system, that includes timelines both for Health Boards to produce budget proposals, responses and final budgets and for Government departments to produce responses, recommendations, consultations and final approvals in a timely manner. It is impossible for any budget process to work out without such a framework, in which all parties have clear goals to meet. The deficit financing situation of the past few years, in which final budget approval has only been forthcoming near or after the end of the fiscal year, prevent any type of long term business planning by Health Boards.

Reinstating line-by-line budgeting would necessitate hiring large numbers of people in the Department of Health and Community Services to undertake the requisite detailed and regular examination of board budgets. Questions currently dealt with at board level regarding the type or extent of services provided would be referred to Government, the authority for approval of service provision. This would almost certainly necessitate the hiring of further human resources in the Department of Health and Community Services to respond to these public requests. The lack of adequate technology and system-wide standards to gather and monitor statistical information needed by the health system will continue to hamper this process, whether the budgeting be line-by-line or global.

Currently the budgeting system is an uneasy hybrid, a global system with frequent and time-consuming line-by-line review using standards that are outdated or have not been shared with the Health Boards. The Association recommends that the statement on global budgeting be reconsidered and abandoned in favour of more detailed and proactive recommendations in this area along the lines suggested above to address the structural issues which are blocking the smooth running of the system. Global budgeting, with the appropriate infrastructure, modern standards and a clear accountable budget process with defined roles and responsibilities, is the most effective way to ensure accessibility and sustainability of health services tailored to the needs of every region in the province.

3.3 Sick Leave and Replacement Costs

In 1999, the total cost of sick leave to the health system, including replacement costs, was calculated to be almost $40 million:

- *1,615,454* paid sick leave hours
- *$25,545,204* paid out in sick leave costs, and
- *$14,128,793* paid in replacement costs.
- for a total of *$39,673,998*

This is a significant drain on the funding available for health services that was barely mentioned in the Report. The Association is particularly concerned about this non-productive usage of health funds, and has been lobbying for a committment by Government to include a new approach to managing non-worked time in issues to be discussed in collective bargaining.

3.4 The Role of the Integrated Boards

The Integrated Boards, Health Labrador and Grenfell Regional Health Services Board, have pointed out the difficulties of comparisons of their operations with those of either the Institutional or the Health and Community Services Boards. The Association would welcome a recommendation that the Integrated Boards form a separate category in the health system, since their health programs and services are delivered in an integrated

manner along the continuum of care, and attempts to separate out funding and services along institutional or health and community services lines always results in misrepresentations and distortions of the data. These have been detailed in the individual comments by the two Integrated Boards.

These difficulties stem partly from the incompletely facilitated global budgeting system discussed above and the attempts by government to add in line-by-line reviews. It has not been completely understood in these reviews that the Integrated Boards do not simply deliver both types of services in a manner directly comparable to other Health Boards, but that the services are delivered in an integrated manner which is significantly different than the Boards focussing on either institutional or health and community services.

3.5 Standards and Benchmarks

All of the reviews of the Report forwarded by individual Health Boards reference difficulties with standards, outdated, unavailable or not communicated to Boards. The Health Boards do not feel that the current standards of care, dated 1995 and developed in the early 1990s, represent any consensus, provincial or national, on appropriate levels for quality service.

In a related issue, the St. John's Nursing Home Board pointed out that the report by Dr. Pat Parfrey, which seemed to be providing some assumptions on which the Report was based, had not been released to their Board nor had they been consulted in its preparation.

The Association is looking for a recommendation from the Special Review Team, that in consultation with Health Boards, standards in every area of operations in the health system be developed, updated, fully communicated and funded for implementation. If these standards are to be used to evaluate performance and fiscal responsibility, it is crucial to ensure that valid measures are chosen, communicated and universally implemented.

3.6 Grouping

Many Boards have serious reservations on the criteria chosen for placing facilities in groups for assessment purposes. The criteria used in the Report have produced some groupings in which individual members are disadvantaged by the use of inadequately chosen measures of comparison. We recognise the time constraints under which the Special Review Team has conducted their investigations, but maintain that these limitations should be clearly stated where circumstances of one group member are significantly different from the others.

3.7 Gaps in Service and New Service Needs

The Association is disappointed that the Report does not identify gaps in services currently provided, nor mention the lack of funding for future service needs. Are the mandated services being provided and are they being provided at the required level with the funding available? This information is necessary in order to fulfill the mandate of the Special Review and determine both whether the health system can afford the mandated services with the current level of funding and whether the health system will be able to respond to new service needs as they emerge.

In connection with planning for future needs, the Association supports the implications of the remark in the Report that requests are dealt with on an ad hoc basis instead of part of a plan. Health Boards have been lobbying for a strategic plan for the health system so that the budget process, funding priorities, and new developments can be addressed systematically using the strategic directions identified in consultation with the Health Boards. This is an essential step to rationalizing and improving the health system and ensuring that all Health Boards are provided with needed standards, benchmarks and goals for their operations. The Health Boards fully support such a planning process.

4 Conclusion

The Association, as stated at the outset, appreciates the difficulties of doing such a Report under the given time constraints, with standards dating back to the early 90s and with the

lack of appropriate technology. After the Special Review Team have reviewed and incorporated the comments from the system, the Association and CEOs look forward to the draft final version of the Report, and to meeting with representatives of the Special Review Team for final discussion before submission to Government.

The Association's major concern is to ensure that the right messages about the health system are contained in the Report. We believe it to be true that the Special Review Team has, as expected, not uncovered evidence of significant mismanagement in the health system. Health Boards cannot continue to be implicitly accused of poor management when the reality is that they have been struggling to maintain the same level of services with rising costs and significantly reduced funding. The Association would like to see a clear statement to this effect.

What is needed now is clear strategic direction from Government, including the difficult decisions on how many and what type of services to provide, with adequate funding to deliver the mandated services to the required level, and to install appropriate modern information technology in a uniform manner across the system.◆