STRENGTHENING THE CAPITAL PLANNING AND COST SHARING PROCESS – *EMERGING DIRECTIONS FOR CHANGE*

A REVIEW OF THE 2003 COST SHARING REVIEW

FINAL REPORT
DECEMBER 2008

Submitted to:

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UBCM and MOHS Steering Committee

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Acknowledgements

This review would not have been possible without the involvement of many people. The consultant's wish to acknowledge all of the individuals who took the time to participate, either in interviews or by supporting the formal survey responses prepared by RHDs and Health Authorities.

We also want to thank the members of the Steering Committee and Working Group members for their support and guidance. Those, in alphabetical order, are:

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Executive Summary

In 2003, the Ministry of Health Services undertook a review of the cost sharing processes established through legislation between the Ministry of Health Services (MOHS), Health Authorities (HAs), and the Regional Hospital Districts (RHDs). The review was conducted through stakeholder consultation and resulted in a report "Ministry of Health Services – Regional Hospital District Cost Sharing Review" which tabled 15 recommendations to address the issues and concerns of key stakeholders.

A key recommendation of the 2003 review was the need to review the implementation status of recommendations resulting from the review.

"The Ministry of Health should review the capital cost sharing process three years after implementation to assess whether the Health authorities and RHDs have developed effective working relationships and are fulfilling the intent of the recommendations."

A 2007 status report developed by representatives from RHDs in BC reiterated many of the concerns that local governments have regarding their relations with the Health Authorities. Following the 2007 status update, the Union of BC Municipalities (UBCM) and the BC Ministry of Health Services decided to undertake a further review to measure the progress made on implementing the recommendations of the 2003 Regional Hospital District (RHD) Cost Sharing Review.

The mandate given to the consultants include:

- The need to review and comment on any barriers that may have affected implementation of prior recommendations;
- The need to provide advice on how to move forward and achieve implementation of the underlying intent of prior recommendations; and
- Comment on any new issues that may have been brought forth during the process.

The process was designed to enable significant stakeholder input, both through an interview process as well as a formal survey. Representatives from the RHDs (23 in total), the Health Authorities (five of the six participated as PHSA does not have a relationship with any RHDs) and the Ministry of Health Services all participated. Their input served to inform the process leading the Review Team to conclude that, while many of the relationship issues previously reported on are now seen to be improving, there continue to be some concerns related to:

- **Predictability of Funding Requirements**
- **Roles and Relationships**
- **Process Issues**
- **Implementation Framework**

The report provides recommendations under each of the categories noted above. The 11 recommendations identified in this report are:

R1. The Provincial Government, through the Ministry of Health Services, is asked to commit to the development of a long range health infrastructure capital plan no later than the 2010/2011 fiscal year. The plan should provide for a minimum planning horizon of three years, with a long term goal of five- to ten-year plans.

R2. The RHDs and HAs are asked to define fixed funding amount that will provide increased predictability of the funding obligations of the RHDs for the majority of all capital initiatives including minor equipment, major equipment, facility renovations and routine capital development projects. This fixed amount should be confirmed for an initial period of three years and then updated in three year cycles based on the long range plans established by Government.

R3. HAs are asked to develop draft capital plans and identify which initiatives it intends to support using the RHD fixed share. Updates to those plans as well as planned and actual use of funds should be part of the regular reporting at scheduled meetings.

R4. The MOHS is asked to work with the HAs and RHDs to update/confirm the definition of capital. This definition should identify a dollar value for large building projects that will be considered outside of the fixed funding model contemplated in Recommendation #2.

R5. The MOHS and HAs are asked to develop educational materials to define the P3 alternate financing model more clearly to all parties, ensuring that any such material addresses concerned noted previously in this report.

R6. The MOHS, RHDs and HAs are asked to clarify principles and mechanisms required to improve communication and enable a more robust process for joint dialogue on key issues related to the overall context within which capital planning decisions are being made.

R7. HAs and RHDs are asked to continue with the development of processes to ensure regular meetings are scheduled between representatives of the Boards of the HAs (e.g. Board Chair) and the RHDs to:

- Enable communication of key strategic and operational initiatives that are underway within the HA as they relate to capital planning and development;
- Provide a forum to support a joint dialogue on key issues for both the HAs and RHDs;
- Offer the RHDs an ability to identify specific questions or concerns they have regarding health care delivery in their communities; and
- Discuss potential capital priorities.

Both HA and RHD should have the opportunity to influence the agenda for these meetings and adequate time should be planned to allow for both formal and informal discussions.

R8. HAs and RHDs are asked to schedule semi-annual meetings between RHD staff and the appropriate staff from the HA. These should be viewed as "working meetings" and could be co-scheduled with the formal Board dialogue sessions suggested above. In this model, the RHD must be willing to accept the HAs authority to designate the most appropriate person(s) to represent them at these meetings.

R9. HAs and RHDs are asked to define mechanisms to allow for ad hoc updates outside of regularly scheduled meetings to ensure timely communication of issues occurs between staff (and possibly the Boards).

R10. The RHDs and HAs are asked to share current templates and tools to be used to support improved communication, project management and cost updates. The intent is to create a toolkit to increase consistency of tools used across all HAs and RHDs.

R11. The MOHS is asked to update the legislation to reflect a new definition of capital.

R12. The MOHS is asked to take the lead implementation role, to ensure that a detailed implementation workplan is developed jointly with UBCM, the HAs and RHDs.

R13. The UBCM is asked to monitor implementation progress on a semi-annual basis and request explanation of any variances to the workplan.

Chapter 1: Why the Project Was Undertaken

INTRODUCTION / BACKGROUND

In 2003, Sierra Systems was engaged by the Ministry of Health Services to conduct a review of the cost sharing processes established through legislation between the Ministry of Health Services (MOHS), Health Authorities (HAs), and the Regional Hospital Districts (RHDs). The 2003 review considered the following questions:

1. What is the appropriate role for RHDs in capital planning and contribution decisions? What is required to implement the appropriate role?
2. What are the capital process concerns of the RHDs, Health Authorities, and the Ministry? What is required to simplify the processes and address the concerns?

The review was conducted through stakeholder consultation and resulted in a report "Ministry of Health Services – Regional Hospital District Cost Sharing Review" which tabled 15 recommendations to address the issues and concerns of key stakeholders. Issues identified were categorized into four themes:

1. Accountability
2. Definition of Capital
3. Procedure
4. Structure

A key recommendation of the 2003 review was the need to review the implementation status of recommendations resulting from the review.

"The Ministry of Health should review the capital cost sharing process three years after implementation to assess whether the Health authorities and RHDs have developed effective working relationships and are fulfilling the intent of the recommendations."

A status report developed by representatives from RHDs in BC was presented in September 2007 to the Union of BC Municipalities (UBCM) Convention session on relations with health authorities, reiterating the concern that local governments have regarding their relations with the Health Authorities. The report also offered a preliminary review of the progress made on implementing the recommendations of the 2003 Review.

Resulting from the September 2007 session, the Union of BC Municipalities (UBCM) and the BC Ministry of Health Services (MOHS) decided to undertake a review to measure the progress made on implementing the recommendations of the 2003 Regional Hospital District (RHD) Cost Sharing Review. Corpus Sanchez International Consultancy Inc. was selected as an external consultant to conduct this review based on their experience in conducting related and similar reviews in British Columbia and other Canadian jurisdictions. The review, under the direction of the Steering Committee was to result in a report that specifically outlined the implementation progress made on all 15 recommendations. Although it was recognized that there may be the need to discuss new issues arising since the 2003 review, the steering committee chose to focus directly on the issues of the 2003 report.

The sections of this report will outline that five years later, there has been some movement on recommendations but many concerns continue. There is also a general sense that the system has not fully implemented the recommendations; however, it was recognized through this review that relationships, processes and communication between all three parties – MOHS, HAs and RHDs – have improved considerably and the environment under which joint capital planning is conducted today is vastly improved over what was occurring when the initial review was conducted in 2003.

Approach and Methodology

When this review was undertaken, the Steering Committee provided clear direction on the scope for the review and expectations for the resulting report of findings in that the overall objective of this assignment was to review progress made on implementing the recommendations of the 2003 Regional Hospital District (RHD) Cost Sharing Review.

The consultants under took a five phase process to reach the desired outcome.

Phases	Timelines
Phase 1: Project Mobilization	July 2008
Phase 2: Developing Baseline Planning Framework	July/August 2008
Phase 3: Stakeholder Engagement	August/September 2008
Phase 4: Issues/Opportunities Identification	October 2008
Phase 5: Reporting	October 2008

Phase 1: Project Mobilization – July 2008

Phase 1 focused on confirming the project management structure and membership for the review Steering Committee. The first interactions between the consultants and the steering committee were focused on Steering Committee interviews, which were designed to confirm scope and highlight issues or concerns in advance.

In addition to interviews with key leaders, this phase initiated data and information collection activities. Information formally requested as part of this review included:

- Health Authority/Regional Hospital District Memorandums of Understanding (MOUs);
- Minutes of Joint Meetings between the above 2 parties;
- RHD Board members and Contact Information;
- Policies, procedures and definitions related to capital funding;
- Financial data on capital spending;
- Any applicable background information/documentation on projects funded outside of the 40% cost sharing model; and
- Lists of stakeholders to be contacted during the consultation process, including but not limited to senior representations for MOHS, HAs, and RHDs

Phase 2: Developing Baseline Planning Framework – July/August 2008

Phase 2 focused on developing a baseline of information that helped to inform the cost sharing review.

The first component of work that needed to be completed during this phase included reviewing the relevant previous studies undertaken as well as other internal reviews and reports that had been conducted. This phase was undertaken to serve two purposes: (1) to inform the current state assessment, and (2) to begin to identify any barriers that have been experienced in the past that need to be incorporated into the change management plan that will ultimately be required to implement recommendations of this review.

Phase 3: Stakeholder Engagement – August/September 2008

As previously discussed, critical to a review of this kind is the need to consult with key stakeholders engaged in the cost sharing process. The information gathered through this phase was used to inform future solutions and scenarios. This consultation was accomplished in two parts – one through a qualitative interview process with identified individuals and/or groups and through a process of written survey submissions responding specifically to the 15 recommendations of the 2003 report. The results of the survey submission will be discussed later in this report. Invitations to participate in this interview process were sent to the following:

- Selected members of UBCM;
- Executive members of all RHDs (e.g. Chair, Vice Chair, and Treasurer);
- Senior administrative staff from RHDs;
- Representatives from Senior Leadership of Health Authorities (e.g. CEO, VP, Planning, CFO);
- Representatives from the Ministry of Health Services; and
- Others identified by the Steering Committee, MOHS, HAs and RHDs.

The majority of these interviews were conducted by teleconference and where circumstances allowed some were conducted face-to-face with individuals in focus groups. Approximately 70 stakeholders were interviewed out of 91 invited (77% participation). It was felt by both the review team and the Steering Committee that this level of participation was significant given that the review was undertaken during the Summer months and considering the many ongoing priorities all stakeholders are presented with on a day-to-day basis.

Phase 4: Opportunity Identification and Follow-up Stakeholder Engagement

Throughout the review process, the CSI team brought together all of our findings to define the key issues and *Emerging Directions for Change*. The purpose of this has included:

- Identification of innovative solutions to address current system issues;

- Consider strategic and operational improvements that can be implemented in the immediate and longer terms;
- Outline preliminary recommendations surrounding priority issues; and
- Identifying change management issues that will need to be addressed.

An interim summary of general themes and findings from the qualitative interviews and survey submissions were presented to the steering committee on September 15, 2008 in preparation for a further validation of themes by stakeholders at the UBCM Convention in Penticton.

In preparation for the final report, an opportunity was provided for stakeholders already attending the UBCM convention to meet to discuss themes and findings arising from the consultation phase of the review. It was also an opportunity to provide feedback to these themes and to discuss recommendations and directions for the upcoming report. Invited to this meeting were RHD Executive members, Administrators & Senior staff, as well as self-identified representatives from Health Authorities and the Ministry of Health Services to participate in this joint session. Information gathered through this joint session validated the information gathered throughout the review and provided critical communication and input to the directions of this final report.

PHASE 5: REPORTING – OCTOBER 2008

This phase focused on issuing two reports: a draft report that was used to facilitate discussion by the steering committee and a final formal report which details the work of the entire project (which is this report).

Chapter 2: Context for Capital Funding in B.C.

Prior to discussing any findings or recommendations arising from this review, it is important to consider how the capital planning and funding environment has changed over time, as this helps to define the atmosphere within which the various funding partners are currently working.

Capital funding requirements for public infrastructure are seen to be growing at a rate that is outpacing the ability of tax revenues to meet the demand. This is linked to past decisions to defer investments in infrastructure, including facilities, equipment and Information Management / Information Technology. As a result of these combined issues, there is now a significant investment required to sustain the current healthcare assets. In addition, the demands for capital requirements to keep pace with population growth, the aging demographic, the implementation of new innovations, and redesign of the health care delivery system, all have significant planning impacts.

There is a sense from the HAs and RHDs that the needs of health care far exceed the total capital funding availability from all funding sources - MOHS, RHDs and Foundations. Given this context, some RHDs are concerned about the expectation surrounding 40% for any project. While this is described as voluntary, some RHDs have a tax base that is not always capable to match the funding request, which leads to an underlying fear that if the 40% is not available from the RHD, that projects will go elsewhere leading to community inequity.

The capital issue is complicated by the fact that capital planning for the HA has been defined more broadly than the original definition under the Hospital District Act. The expanded definition represents an ongoing issue of concern for RHDs and needs to be addressed.

Finally, as the BC healthcare system has significant operating costs, there will continue to be a need to have redesign initiatives, some of which will require capital investment to achieve the cost efficiency and help enable the system to address operational issues (e.g. health human resources pressures) and match the healthcare needs over the next 10 to 20 years. Given the potential impact of operational issues on capital, the HAs will need to provide the RHDs with a longer term perspective on the capital plans and the benefit of the investment to the larger community needs.

Chapter 3: Recommendation By Recommendation Review and Update

As previously discussed in this report, the review included stakeholder consultations through an interview process. As a component of consultations, and supplementary to interviews that were undertaken with key stakeholders from the Union of BC Municipalities (UBCM), Regional Hospital Districts (RHDs), Health Authorities (HAs), and the Ministry of Health Services (MOHS), participation was requested in completion of a survey submission.

From the 15 recommendations of the 2003 Sierra review and status of implementation, respondents were asked to identify the top 5 recommendations that reflect their greatest concern at this time, and respond to the following five (5) specific questions for each they identified. The questions were as follows:

1. What is the current status of implementation of this recommendation for your RHD or HA?
2. What are the barriers to full implementation of this recommendation?
3. Are there any new significant new issues or concerns that have arisen during the implementation process?
4. What are the risks and critical success factors in implementing the recommendation?
5. In order to fully implement the recommendation for your RHD or HA, what are your recommendations on how to successfully move forward with implementation?

14 of 23 RHDs and four (4) of five (5) geographically-based HAs[1] responded to the survey. It is noted above that survey respondents were asked to note the *top 5 recommendations that reflect their greatest concern at this time,* however, it should be noted that many did not prioritize their responses (i.e. they noted all recommendations as important or noted five recommendations, but did not state which of the five was deemed most important).

The intent in asking for the information to be clustered around top 5 issues was to determine which of the issues continue to be of greatest concern and then focus the discussion of the 2003 Recommendations around those issues. Given the variation in responses, this section of the report has been prepared to reflect an update on all recommendations, presented in their original order, as opposed to in order of potential current priority.

That is not intended to suggest that the survey responses were not valuable. Indeed, survey responses were collated and integrated with the additional qualitative input obtained through the individual and group interviews to provide a consolidated set of observations on each of the original 2003 Recommendations. These observations are presented below.

[1] Note: PHSA was not included in the study as none of their programs have an RHD partner

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

2007 RHD Observations[2]:

20 of the 23 Regional Hospital Districts originally signed Memorandum of Understanding (MOU) Agreements with their Health Authorities. Some of the RHDs have subsequently considered those MOU's to not be in force and have chosen not to "renew" them. Some also have independent protocol agreements. Relations and communications have been improving in most cases.

2008 Review Observations:

The Sierra report noted that the model leads to a dual accountability circumstance in which RHDs are accountable to their local taxpayers while the Health Authorities are accountable for health outcomes to the Minister and the Government of BC. This duality is the underlying cause of much of the tension surrounding the relationship and the funding model.

The Review team found that relationships continue to be a significant issue surrounding cost sharing. Despite reported improvements in relationships, many RHDs continue to express some concern surrounding the need to be viewed as "true partners" in the larger health care delivery system, and not just a funding source for capital projects. While this will be discussed in more length in the next section of this report *(Overarching Themes)*, this is grounded in a larger issue surrounding lack of clarity and consensus on roles for the RHDs and the need to address the accountability relationship that they have with the local electorate, as flagged by Sierra in 2003.

With regard to the issue of "voluntary" contributions, most RHDs acknowledge that they theoretically can (and some do) refuse to approve the full 40% project requests from HAs, but they feel that it is risky to do so as the project could be placed at risk and the local community could lose needed investments.

The 40% cost sharing issue is also complicated when an HA is considering consolidation of services in Regional Centres. When this happens, the local RHD (i.e. the one that is in the community where the Regional Centre may be established) would likely be asked to cost share a facility that serves a larger geographic area. Future funding processes may need to consider how this issue will be addressed.

[2] The RHD Observations were included in an update report from 2007 and do not necessarily reflect the views of the other two partners in this process – the MOHS or the HAs.

Sierra Recommendation 2: Health Authorities must be unfettered by cost-sharing requirements in their ability to provide required health services regardless of the fiscal capacity of a region.

2007 RHD Observations:

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

2008 Review Observations:

The Sierra report noted that this recommendation was intended to reflect the concept that decision making for capital could, and should, be buffered from the political process so that the HAs could be true to their mandate to deliver services and achieve improvements in health outcomes. The intent was to remove the Ministry from the traditional capital process and allow the Health Authorities to deliver their complex mandates. And yet, the reality (as noted under Recommendation 1), is that the RHDs carry an accountability to local taxpayers that is grounded in a political relationship model. So even if the provincial government was successful at extricating itself from a political model, the RHDs would continue to have this link.

The entire issue is complicated, but the general agreement from stakeholders is that HAs are not unfettered and political realities may make it challenging to address this recommendation in the short term. The largest barrier is the sense that capital needs far exceed the ability to fund initiatives and hence government will need to maintain a high degree of control over capital decisions.

That being said, there is a sense that the process can be more transparent (e.g. rationale for decisions shared with all parties), can proceed with more clarity (e.g. capital more clearly defined) and can be pursued through a more cooperative model where all partners feel appropriately involved and engaged (e.g. relationships continue to evolve and improve).

The MOHS had been developing a tool to address prioritization and funding linkages. The tool, first developed in 2007, included a mechanism to reflect a points-based system that can help to inform prioritization decisions. In its initial form, the tool included a bonus point component that recognized the availability of RHD funding as a factor that could increase the point value for a project. This raises a concern that the capacity of an individual RHD to provide funding can influence a final decision, which would not be consistent with the concept of the HA being *"unfettered by cost-sharing requirements in their ability to provide required health services regardless of the fiscal capacity of a region."*

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

2007 RHD Observations:

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

2008 Review Observations:

The Sierra report discussed the fact that capital projects involve HA, RHD and Foundation (philanthropic) funding sources and the intent of the recommendation was to note that funding decisions must be a result of sound information exchanges, discussion and open decisions by the RHDs.

Linked to the discussion surrounding Recommendation 1, RHDs report that 40% is expected and debate or discussion is not always welcomed or encouraged. At the same time, a few RHDs report that they have been told that they can fast track a lower priority initiative if they choose to fund 100% of the costs. This raises two possible concerns regarding the longer term expectations of funding projects more than 40%:

- Decisions to support some projects at 100% could limit an RHDs ability to pay for other initiatives, even if that request is only for 40%, and
- It could set a precedent whereby other RHDs could be expected to fund projects at 100%.

Despite these possible concerns, the majority of RHDs report that they want to retain the flexibility to fund projects at, below or above the general guideline of 40%.

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

2007 RHD Observations:

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

2008 Review Observations:

The Sierra report's description of this recommendation noted that the capital planning role of the Health Authorities logically leads to a consideration of what happens in the event of a cost overrun on a particular project. Traditionally, there has been an expectation that management of such issues would be jointly managed between the local health organization and the RHDs, but the underlying principle is that the Health Authorities take responsibility for cost overruns while maintaining the capacity to seek RHD support as needed. This is closely linked to the next recommendation.

The 2007 RHD Observations Update shifts the discussion to the need to ensure that HAs commit to funding operational costs if they request capital funding support from an RHD. On this point, we note that, intuitively, any plan to build a facility suggests that the organization – in this case the Health Authority – is committed to operating that facility. At the same time, capital projects can take years to complete, during which time a number of unforeseen factors can affect the plan, such as: human resource changes that affect the ability to staff and deliver care, changes to operating or capital funding, construction cost escalation, changes in government and changes in HA & RHD staff. These realities may impact the ability of the HA to follow through on the original intent and they must have the ability to adapt plans as needed.

Another issue is the need to tie planning commitments to long term funding commitments – and this requires commitments to budgeting strategies beyond a one-year planning horizon.

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

2007 RHD Observations:

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

2008 Review Observations:

Sierra noted that this recommendation (coupled with #4 above) was intended to provide the best possible opportunity for the development of real partnerships at the local level while meeting fundamental principles related to the need to balance the RHDs local accountability with delivery of the HAs mandate. As of 2008, the issue remains the same – the RHDs expect to be viewed as equal partners in the planning process, and are generally willing to commit to the original request when this partnership is in place. However, when overruns occur, the need to go back and raise more money can cause issues, especially if a bylaw has been formally raised and approved to provide the original contribution. Raising a second bylaw on a previously approved project to address overruns can be problematic. Notwithstanding this, RHDs want to ensure that the ability to decline to pay for overruns should be maintained.

Sierra Recommendation 6: For the purposes of RHD cost sharing, the categories of capital should be simplified:

a. Projects or single pieces of equipment with a value of less than $100,000

b. Projects or equipment with a value greater than $100,000

c. The classification of equipment value must take into account the overall value of a 'system' of which a single piece of equipment is a part.

d. P3's require the development of clear accounting definitions to recognize ownership.

2007 RHD Observations:

RHDs are concerned with clear accountability in P3 projects.

2008 Review Observations:

The lack of consensus surrounding the definition of capital continues to be an issue as RHDs express ongoing concerns that it is no longer clear how their contributions are being used. RHDs are also concerned that they are now being asked to contribute to an ever-widening set of projects that reflect the HA mandate, but are at odds with the original focus outlined in legislation (e.g. hospital facilities and equipment versus long term care facilities and information technology).

Beyond the question surrounding definition of capital, P3 continues to be a concern for some RHDs. Some of this relates to the local accountability issue and the public perception that local jobs will be lost due to P3s. There is also a concern that the P3 model results in contributions of taxpayer money to a for-profit entity. Most of these concerns reflect a general misunderstanding of the P3 model and the controls that the Provincial Government has put in place to ensure that the public's interest is met. Given this, the MOHS and HAs should provide additional information on the P3 transactions to allow the RHD to understand the transaction, ownership of assets, the risk transfer and also the value for money proposition in P3's.

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

2007 RHD Observations:

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

2008 Review Observations:

The majority of RHDs provide lump-sum funding for minor capital items and there seems to be limited concern about this model. One issue is that some RHDs want assurances that these contributions are being used appropriately and that processes exist for effective reporting and accountability back to the RHD regarding any expenditures drawn from the lump-sum funding.

This process is in place for most RHDs and HAs, but needs to be in place consistently on a province-wide basis.

At the same time, some RHDs stress that contributions remain voluntary and need to be subject to appropriate processes for joint discussion and approval.

Sierra Recommendation 8: A change in the definition of capital should not increase the overall ratio of financial contribution of the RHDs or require RHDs to assume new debt beyond historical and projected funding levels for traditional hospital capital projects.

2007 RHD Observations:

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

2008 Review Observations:

This issue is directly linked to the definition of capital (discussed under Recommendation #6) and reflects a need to gain consensus on two issues: renewed definition and the concept that contributions are indeed voluntary.

The biggest concern for RHDs is related to overall affordability given a growing number of potential projects which could limit the RHDs ability to fund projects which local taxpayers have traditional supported (e.g. new hospital facilities).

There is also some concern that any commitment to maintaining historical funding levels assumes that historical funding is somehow a predictor of actual need, which all parties agree is not the case, If the principle of maintaining historical levels is accepted, some are also concerned that it could be used to entrench historical variation/inequities in funding levels between RHDs

Sierra Recommendation 9: Implementation of the recommendations process should begin in the fall of 2003 with a joint planning meeting between each Health Authority and its RHDs.

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

2007 RHD Observations:

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

2008 Review Observations:

As noted previously, both the RHDs and the HAs express significant frustration at the inability to plan beyond one year due to the fact that MOHS is only authorized to provide firm commitments in one-year cycles. For the RHDs, this leads to unpredictability in cash flow planning and management and a perception of increased risk. For the HAs, it leads to frustrations surrounding the ability to develop concrete plans for infrastructure investment.

Sierra Recommendation 11: In the fall, before Health Authority and RHD budgets are finalized a joint planning meeting (or series of meetings) should be held to discuss the content of the Health Authority's five-year capital plan.

2007 RHD Observations:

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

2008 Review Observations:

This recommendation is directly linked to the inability to date to develop a process that allows for five-year plans, but it also goes to the heart of the relationship issue described previously. Many RHDs have expressed frustration with the regular planning meetings in the past, noting that they did not feel that the meeting reflected the true spirit of a partnership (as contemplated by the 2003 Sierra report). On a positive note, most RHD`s report that the relationships are improving and some have specifically noted that the regular meetings are becoming more productive and valuable.

Sierra Recommendation 12: The joint planning meeting should be used to meet education objectives by providing an opportunity for the Health Authority to explain its planning assumptions as well as the specific health outcomes that it is pursuing.

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

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

2007 RHD Observations:

Some RHDs still feel that they are approached with already decided plans and budgets – simply asked to make their contribution rather than provide local input into planning processes. RHDs still feel that the coordination of different budget cycles creates difficulties. Cash management is also an issue where the RHD has committed to funding a project and the HA does not request the funds in a timely manner.

2008 Review Observations:

As noted above, the relationships between HAs and RHDs appear to be improving and the dialogue is becoming more focused on enhancing the partnership. Notwithstanding this, there is an ongoing need for attention to these relationships and processes for improved communication and team building. All of the meeting forums need to be designed to strengthen communication processes, build better working relationships and balance the duality of accountability that is structurally built into the funding model. With the different budget cycles, there may be an opportunity for both HAs and RHD to meet in the fall of the

calendar year to share the priorities and RHDs could determine funding ability and potentially provide tentative approval of the funding subject to final MOHS approval of the project.

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

2007 RHD Observations:

The Hospital District Act (RSBC 1996) Chapter 202 still contains references to "hospitals and hospital facilities".

2008 Review Observations:

The Act remains outdated and may need to be revised to reflect the current day practice. While some revisions reportedly were made to legislation, most feel that more are required to update the roles, responsibilities, and processes. At the same time, it was noted at the Steering Committee meeting that there may have been a decision after the 2003 Review that changes to the Act could be overly restrictive and, given the voluntary nature of the funding partnership, may be unnecessary. In other words, if contributions are voluntary on the part of the RHD, then they can still fund projects outside of the traditional definition *if they choose to do so*, and therefore the Act may not need to be revised at all.

Chapter 4: Recommendations for Moving Forward

As noted in Chapter 1 of this report, the Review process utilized two processes to enable stakeholder engagement – a written survey, and a series of interviews. The input was used to inform the discussion of each Sierra recommendation in the previous chapter, but it was also used to identify the overarching themes that could be used as a framework for organizing recommendations. In the 2003 Sierra report, there were four themes: Accountability, Definition of Capital, Procedure, and Structure. This chapter outlines themes that have been identified in 2008 to enable implementation of the original recommendations.

OVERARCHING THEMES

Throughout the review process, it was evident that although there were variances between particular priorities for stakeholders there was a general consensus on the themes and issues surrounding the 2003 recommendations. The majority of stakeholders interviewed from the MOHS, HAs and RHDs indicated that the 2003 recommendations covered the key issues at that time. A number of changes occurred when the new HAs where formed in 2001 and many individuals that had the knowledge and relationships with the RHDs were gone.

Moving forward to 2008, the mandate for this review was to identify recommendations that would enable the full implementation of the original Sierra recommendations. As previously discussed in Chapter 3 there has been movement on many of the previous recommendations. In conducting this 2008 status review, four key themes emerged that provide renewed focus to address the outstanding issues that, to date, have limited the ability to fully implement all Sierra recommendations. The themes identified are:

- **Predictability of Funding Requirements**
- **Roles and Relationships**
- **Process Issues**
- **Implementation Framework**

Each of these themes, and 2008 review recommendations related to each, as discussed in the sections following.

Predictability of Funding Requirements:

The central issue in many of the recommendations in the 2003 Sierra report was the need for predictability of funding commitments. This was expressed in many ways, ranging from recognition that the 40% RHD contribution is voluntary to calls for long range capital plans, improved definitions of capital and a need for the HAs to be unfettered by the cost sharing process as they plan and deliver on their mandate.

Two of these issues require further discussion:

- The need for long range capital plans, and
- The need for the RHDs to be able to ensure ongoing affordability of their funding commitments

All parties agree that **long range capital plans** are desired and reflect best practice (as defined by practices in virtually all other industries and sectors). This is more commonly seen in private industry where, as McKinsey and Associates[3] note that two fundamental issues that must be part of any effective strategic plan are:

- *Providing facilities:* Providing the plant, equipment, and other physical facilities required to carry on the business.
- *Providing capital:* Making sure the business has the money and credit needed for physical facilities and working capital.

Both of these principles reflect the need for both a long range capital plan and a cash flow strategy that aligns with that plan, but some people interviewed during the consultation process question whether the same is possible in a public sector environment. The Review team submits that, while it may not be the norm to date, it is both possible and essential.

The Commonwealth of Virginia in the United States[4] recognized the need for long range capital planning in the mid-90s when it defined the six best practice principles that would guide its planning processes, which are:

- *Long-range planning horizon:* Capital requirements must be examined over a four- to ten-year period to adequately identify and assess capital construction and renovation needs. The long-range planning process helps decision-makers to prioritize capital obligations and assist them in making informed choices about managing debt. It also facilitates the identification and evaluation of options and minimizes the unnecessary expenditure of public funds.
- *Integration of capital budgeting with strategic planning:* Through the strategic planning process, agencies identify their mission and program objectives and assess the needs of their customers and the environment in which they are operating. These strategic plans should be the starting point for identifying capital requirements and determining the

[3] Bruce D. Cox, AIA, *Methods, Metrics, and Concepts for Building Dynamic Strategic Planning Processes*, Newsletter for the Facility Management Knowledge Community, 2008.
[4] Donald Darr, *The Benefits of Long-Range Capital Planning – The Virginia Experience,* Public Budgeting and Finance, Fall 1998.

gap between current and future needs. During this process, alternatives should be assessed, including non-capital options.

- *Limitation of debt financing:* There needs to be a measure of debt affordability that identifies the amount of tax-supported debt that may be prudently authorized consistent with financial goals and capital needs. Rating agencies view control of tax-supported debt as a key factor affecting credit quality.
- *Quality information including an inventory of assets and needs:* Policymakers must have up-to-date information and comprehensive data and information systems to make effective decisions.
- *Good communications:* Good internal communication allows all levels of an organization to be familiar with the agency's mission and strategic goals. Dialogue and feedback between line and central agencies is important to quickly resolve questions or problems. A central agency can also serve as a clearinghouse for disseminating state-of-the-art techniques.
- *Monitoring of performance:* Agencies must be held accountable for results through appropriate levels of review. Once initiated, there needs to be a systematic way to monitor a project's progress and evaluate performance. For example, performance measures can be used to assess completion targets and cost estimates. The evaluation of results allows lessons learned to be incorporated into the capital decision making process.

Looking at just the first two principles, the MOHS and the HAs have started the process for longer range planning, with some initial attempts to define capital needs over time. While there have been some challenges with this process, it is clear that it needs to continue and that the RHDs need to be active participants. This would go along way to addressing the issue of **ongoing affordability** as it would predict the overall cost and enable discussion with the RHDs regarding affordability and financing options. The RHDs already have multi-year financial plans for revenue from the community tax base, but they are concerned that capital costs can change because of the current model that relies on one-year planning cycles. A model grounded in the above principles would move beyond the one-year planning horizon and address many of the underlying concerns.

While all parties recognize the benefits of longer term planning horizons that would provide more predictability over future funding needs, some suggest that political planning cycles can impact the ability to commit to long range plans. The Virginia model also contemplates this issue, acknowledging that the final prioritization rests with the Governor and his cabinet and ultimately will balance their policy goals and the availability of funds. The process also allows the Governor to fund projects that are declared to be of an emergency nature. These projects are managed outside of the normal cyclical planning process and do not affect the capital funding commitments included in the long range plan.

To advance the cost-sharing model and meet the needs of all parties surrounding *Predictability of Funding Requirements*, the following recommendations are offered:

R1. The Provincial Government, through the Ministry of Health Services, is asked to commit to the development of a long range health infrastructure capital plan no later than the 2010/2011 fiscal year. The plan should provide for a minimum planning horizon of three years, with a long term goal of five- to ten-year plans.

R2. The RHDs and HAs are asked to define fixed funding amount that will provide increased predictability of the funding obligations of the RHDs for the majority of all capital initiatives including minor equipment, major equipment, facility renovations and routine capital development projects. This fixed amount should be confirmed for an initial period of three years and then updated in three year cycles based on the long range plans established by Government.

R3. HAs are asked to develop draft capital plans and identify which initiatives it intends to support using the RHD fixed share. Updates to those plans as well as planned and actual use of funds should be part of the regular reporting at scheduled meetings.

R4. The MOHS is asked to work with the HAs and RHDs to update/confirm the definition of capital. This definition should identify a dollar value for large building projects that will be considered outside of the fixed funding model contemplated in Recommendation #2.

R5. The MOHS and HAs are asked to develop educational materials to define the P3 alternate financing model more clearly to all parties, ensuring that any such material addresses concerned noted previously in this report.

Above 2008 review recommendations linked to ability to fully implement Sierra recommendations: #1, #2, #3, #4, #5, #6, #7, #8 and #10

Roles and Relationships:

One of the major issues surrounding the inability to fully implement Sierra's recommendations for the cost sharing model are grounded in the conflict surrounding roles and relationships that occurred following the regionalization of the health care system.

Where We Have Come From

Prior to regionalization, RHDs had relationships with individual hospitals (often representing individual communities) and the RHD had a higher degree of influence over the prioritization of capital priorities within the District. Much of this influence emanated from the fact that a single RHD had multiple relationships with individual hospitals and needed to be fully briefed on hospital plans in order to have an informed discussion on potential priorities.

Following regionalization, the Health Authorities assumed this prioritization role as the hospitals now were part of a larger whole and multiple RHDs now had to form relationships with the single HA, a reversal of the prior model. This led to a gap or void for the RHDs who perceived that they were no longer provided the level of information that they had previously received, and therefore, were not in the same position to discuss and defend planning decisions to the local electorate.

At the same time, the HAs were expected to develop capital plans that included more than just hospitals, and more than just a single community (as represented by that hospital). So a second shift occurred where the focus of planning was broadened and the potential financial obligations for RHDs were expanded. In addition, many of the individuals that RHDs had worked with at hospitals were no longer in the system, so RHDs did not know who to contact to raise concerns and address questions.

The end result was that traditional relationships, responsibilities and accountability models (many of which were informal) were eliminated, but there was no clarity provided as to what would take their place. RHDs – seeking the same level of dialogue and influence – found themselves in relationships with new individuals, new organizations and operating under a new (albeit yet unwritten) set of rules.

Where We Are Now

This history is important because there continues to be some issues related to role clarity between the parties, varied perceptions of accountability requirements and linkages, and the need for overall improvements in relationships. RHDs express a desire to be more actively engaged as partners in processes to identify health care issues and define priorities, while HAs want to ensure that they are able to fulfill their mandate as defined by the provincial government. These relationship issues reflect an area that requires attention on an ongoing basis.

On a positive note, the Review team found that the vast majority of RHDs report that communications have improved between HAs and RHDs since the 2003 review. These improvements include regular meetings scheduled between the parties and for discussion of the HAs capital plan and priorities. Most also now have Memorandum of Understanding (MOU) agreements between RHD and HA to clarify both parties requirements and expectations.

Although communication and relationships are generally reported to have improved, there are still some that need to work to improve the understanding of the issues from both HAs and RHD perspectives of the Health Services requirements for communities. Core to the issue is a need to confirm the partnership relationship between the HAs and RHDs. The attributes of an effective partnership, as identified through the consultation process, include:

- An underlying valuing and respect for the role that each partner plays and how that role benefits all parties in the relationship;
- Timely and transparent dialogue, consultation and information sharing that ensures that all partners are appropriately involved in the planning process that leads to a decision affecting all partners;
- Alignment of planning processes to meet the needs of all parties;
- Harmonized performance monitoring and review regarding resource allocations.

Central to the partnership issue is that RHDs – as representatives of local government leaders – feel that they have a strong and legitimate role to play in the areas of citizen engagement. To fulfill that role, the RHDs need to be better informed surrounding the HAs strategic priorities and operational challenges, as well as the prioritization processes for local health initiatives.

HAs, by contrast, raised concerns that any process to broaden the dialogue between HAs and HD's beyond just capital priorities could lead to further conflict or tension as it could lead to the discussions that drift into operational areas that are clearly the purview of the HA when it comes to decision making. The key will be to agree on whether or not the role is appropriately focused and then structure communication mechanisms appropriately.

As the partnership model evolves, it will be important to ensure that all parties understand how their roles fit within an overall decision making framework. To assist with clarity, the review team has created the CSI Decision Making Model which is referred to as DRIVE. DRIVE is an acronym for the five roles that exist within a formal decision making framework. Each is described in the table below:

Role in Decision Making		Organizational Mandate
D	The formal *Decision-maker*. He or she is ultimately accountable for the decision – good or bad – and must have the authority to resolve impasse in the decision-making process as well as during implementation.	MOHS
R	*The Recommenders*. Typically may consult with others, but they have responsibility to develop the ultimate proposal and recommendations Someone is typically assigned responsibility to formulate an initial proposal or response to a problem or issue that is being examined.	Health Authority
I	Those with *Input* typically will play a key role in enabling an implementation of a recommendation because they were part of the consultation process These individuals need to be consulted on the decision, and their advice is typically sought by a recommender, as well as by the ultimate decision maker, prior to the process being finalized.	Regional Hospital District
V	Those with *Veto* power must agree with the recommendation prior to it going forward for a formal decision. If these individuals do not agree, then the proposal is revamped until agreement can be reached.	N/A
E	Those chosen to *Execute.* This stage provides clarity regarding timing, expected deliverables/outcomes and consequences for failure to act once a decision is made.	Health Authority

In the current capital planning model, the HAs have the R role as they formally recommend priorities to MOHS. RHDs should have an input role as they are key participants in the dialogue on issues. No one has a V (veto) and MOHS and the provincial government ultimately have the D and get to decide. Once decisions are made, the HA carry the E role as they have responsibility to implement.

To advance the cost-sharing model and meet the needs of all parties surrounding *Roles and Relationships*, the following recommendations are offered:

R6. The MOHS, RHDs and HAs are asked to clarify principles and mechanisms required to improve communication and enable a more robust process for joint dialogue on key issues related to the overall context within which capital planning decisions are being made.

R7. HAs and RHDs are asked to continue with the development of processes to ensure regular meetings are scheduled between representatives of the Boards of the HAs (e.g. Board Chair) and the RHDs to:

- Enable communication of key strategic and operational initiatives that are underway within the HA as they relate to capital planning and development;
- Provide a forum to support a joint dialogue on key issues for both the HAs and RHDs;
- Offer the RHDs an ability to identify specific questions or concerns they have regarding health care delivery in their communities; and
- Discuss potential capital priorities.

Both HA and RHD should have the opportunity to influence the agenda for these meetings and adequate time should be planned to allow for both formal and informal discussions.

R8. HAs and RHDs are asked to schedule semi-annual meetings between RHD staff and the appropriate staff from the HA. These should be viewed as "working meetings" and could be co-scheduled with the formal Board dialogue sessions suggested above. In this model, the RHD must be willing to accept the HAs authority to designate the most appropriate person(s) to represent them at these meetings.

R9. HAs and RHDs are asked to define mechanisms to allow for ad hoc updates outside of regularly scheduled meetings to ensure timely communication of issues occurs between staff (and possibly the Boards).

Above 2008 review recommendations linked to ability to fully implement Sierra recommendations: #1, #11, #12, #13 and #14

Process Issues:

Many of the process issues will become less of an issue if the recommendations outlined in the previous two sections are implemented. Notwithstanding that, there continue to be some potential challenges:

- The Sierra Report called for an updated definition of capital. This remains an issue and likely needs to be addressed.
- A number of other process issues that were raised including timing issues and the need for alignment of planning calendars, communication and project management, reconciliation of budget versus actual costs and challenges associated with monitoring projects through implementation.
- The P3 model for funding new investments continues to be an issue of particular concern for RHDs and requires ongoing discussion and clarification.

To advance the cost-sharing model and meet the needs of all parties surrounding *Processes*, the following recommendations are offered:

R10. The RHDs and HAs are asked to share current templates and tools to be used to support improved communication, project management and cost updates. The intent is to create a toolkit to increase consistency of tools used across all HAs and RHDs.

R11. The MOHS is asked to update the legislation to reflect a new definition of capital.

Above 2008 review recommendations linked to ability to fully implement Sierra recommendations: #10, #11, #13, #14 and #15

Implementation Framework:

The Sierra report called for the following mechanism to review implementation:

"The Ministry of Health should review the capital cost sharing process three years after implementation to assess whether the Health authorities and RHDs have developed effective working relationships and are fulfilling the intent of the recommendations."

While a three-year review was suggested, stakeholders noted that there was no formal implementation framework and no party was given formal accountability and performance framework to ensure implementation of the recommendations. As many of the recommendations would have required significant policy and legislative changes, the absence of this framework was identified by some stakeholders as one of the barriers to implementing the report.

To advance the cost-sharing model and meet the needs of all parties surrounding *Implementation*, the following recommendations are offered:

R12. The MOHS is asked to take the lead implementation role, to ensure that a detailed implementation workplan is developed jointly with UBCM, the HAs and RHDs.

R13. The UBCM is asked to monitor implementation progress on a semi-annual basis and request explanation of any variances to the workplan.

Chapter 5: High Level Implementation Plan

To assist UBCM and the MOHS in moving forward, we offer the following advice surrounding implementation.

Step 1: Receiving the Report

The first step is a critical point where MOHS and UBCM formally receive the findings report. This action does not imply that MOHS and UBCM agrees with each and every recommendation, but rather that the organization has accepted the report and is committed to moving forward. The process starts with MOHS (or UBCM) initiating a communication process to show the overall commitment to move forward with implementation and be clear about their intents for how they are going to proceed with the consultant's report. In our experience, this communication should occur within 90 days of the report being formally submitted to UBCM.

Step 2: Issuing a Formal Response

Once the report has been received, the MOHS, HAs and RHDs should be provided a clear timeline for responding to the content and confirming if they are comfortable with the recommendations as presented. This process should confirm which recommendations are accepted without change, accepted with minor modifications or changes suggested, and rejected because they are either inappropriate or considered no longer relevant. For recommendations that will proceed to implementation, there should be a prioritization process and an overall timeline to achieve full implementation.

Step 3: Enabling Critical Success Factors

Critical Success Factors (CSFs) identify specific actions or supports that must be available to proceed with the implementation. In many cases, the success factors reflect specific areas of need or investment that the organization must develop. The following outlines suggested CSFs for this initiative:

- **A Unifying Vision and Sense of Purpose.** Pursuing change of this magnitude can be enhanced by taking some time upfront to work with organizational leaders to raise their level of understanding of the issues, their comfort with their roles and to build consensus and support for the change strategy. It may also be useful to articulate a renewed statement showing commitment to addressing the issues. This part of the process needs to focus on articulating individual roles and responsibilities for each partner as well as concepts necessary for teamwork.

- **Stakeholder Engagement and Communication Strategies.** It is critical that the organization ensure that all stakeholders have a chance to hear the report findings and develop a shared understanding that:

    1. That changes are required;
    2. What those changes are; and

3. That changes will be implemented.

A stakeholder engagement and communication strategy will be pivotal to the successful rollout of this report and the subsequent implementation of recommendations.

- **Leadership to Guide and Support Change.** Leadership will be key to the success of the implementation effort. It should start with the senior leaders at MOHS, RHDs and Health Authorities, but may also need to include formal government endorsement. Also need to note that someone needs to take responsibility for implementation – our recommendation is MOHS. UBCM (or alternate) to play monitoring role.

- **Supporting Project Management Capacity.** Project management support will also be key. We would recommend the appointment of an internal project manager to lead the support rollout and ensure that implementation stays on track. The project manager will have to work closely with RHD and HA leadership, who in turn, will work closely with staff to effect change and ensure that the report maintains a renewed and revitalized focus. In our experience use of project management tools to track implementation and to provide timely executive over-sight is extremely helpful.

Step 4: Building a Viable Implementation Plan

Once the report has been received and endorsed and critical success factors have been identified, MOHS and UBCM must transition to building a viable implementation plan. This phase, which we typically refer to as Mobilization, is an important planning activity where required priorities are defined, project schedules which detail timelines and deliverables are established, and resources are identified and assigned to the project.

Step 5: Implementation and Evaluation

Once the report Mobilization is underway, UBCM will be able to move forward with monitoring as per defined timelines (e.g. quarterly or semi-annually)

Timing Considerations

Based on experience in other projects, we would suggest that Steps 1 through 4 of this implementation should be able to be completed by September of 2009, but MOHS and UBCM should be asked to define specific timelines. UBCM should commence its semi annual monitoring role within six months of development of a formal implementation plan.

Chapter 6: Other Considerations

As with the Sierra Report, this review found that issues came up in the process that were outside of the scope of work given to the Review Team. Most of these relate to questions surrounding the **overall appropriateness and applicability of the cost sharing model.** People raised a number of issues related to this including:

- RHDs do not exist in the Lower Mainland meaning that the population within the GVRD do not contribute to capital projects for hospitals through a local government taxing authority. This relates to a decision years ago to have the GVRD provide funding for capital expenditures for transit rather than Hospitals. At the time it was believed that the trade off between transit and hospital was fairly equal, however with the province and other Regional Districts putting more money into transit, the question has once again been raised as to the fairness of this arrangement.

- Variation in taxation levels, amounts paid in real dollars and variation on percentages of projects funded by RHDs creates a sense of inequity that may need to be addressed more directly in the long term. Sierra noted that no RHD should be required to pay more than they had historically, but some people question if historical amounts were valid or appropriate.

- Overall questions of affordability for the RHDs to pay for capital costs requires a more in-depth review, and new targets/processes may be required (based on an underlying principle of ability to pay).

- Issues related to cost sharing capital projects in RHDs with large First Nation populations are acknowledged as complex and beyond the scope of this report, but will require some focus in the future.

- The emerging role of the Ministry of Finance in the capital planning and prioritization process has been identified as an issue requiring some clarification.

- Finally, some RHDs continue to question whether they should continue to exist and be expected to fund capital costs in health. Some HAs also question whether RHDs should exist for this role. (Note: this was identified in the Sierra Report but there is a general sense that fewer parties question the role now than did in 2003).