

**Minister's Task Force  
on Regionalized Health Care in Nova Scotia**

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**Final Report and Recommendations  
July 1999**

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## **Appreciation**

The Task Force owes a great debt of gratitude to the people of Nova Scotia, including recent recipients of health care services and members of the general public; addiction and public health staff; management staff in home care and long-term care; nurses, physicians and other acute care front-line providers; acute care facility site managers; Community Health Board chairs and members; and board members and senior management of Regional Health Boards and Non-Designated Organizations.

All participants willingly shared with us their comments, criticisms, hopes, and aspirations for a better health care system. The universal concern we sensed throughout the province for health and welfare is a typically Canadian characteristic, one that sets us apart from many other countries. This concern gives us confidence that our system of health care will be strengthened progressively in years to come.

We believe that implementation of our recommendations will be an important step in that direction.

## **Executive Summary**

The Minister's Task Force on Regionalized Health Care has analyzed the current state of regionalized health care in Nova Scotia. The mandate of the Task force was not to investigate the validity of regionalization but to study its strengths and weaknesses and present its recommendations for improvement. This report presents its conclusions and recommendations.

### **Views Expressed on Regionalized Health Care in Nova Scotia**

As part of its research for this evaluation of regionalized health care, the Task Force invited many individuals and groups involved in the health care system, including health care providers and the public, to provide their views on regionalization so far. The results show that while these stakeholders accept that health care must be developed beyond the walls of facility care, they feel they have less input into the health care system in their area since community hospitals came under the governance of Regional Health Boards. They feel that community representation at the regional level is inadequate.

The results also show that regionalization is widely misunderstood. In general, both providers and consumers are critical of the system, believing that its main goal is to cut costs. Many tend to attribute such deficiencies as physician and nurse shortages, bed reductions, and long waiting times to regionalization although many of these problems occurred before or at the same time as regionalization.

### **Source of the Problems**

Given that the public generally agrees with a community-based approach to health care, the Task Force believes that dissatisfaction with the current system has resulted from incomplete implementation of regionalization, and in some instances, an appearance of incomplete regionalization, such as isolation of the Regional Health Boards, slow decision making, increasing layers of administration, increased travel costs, rather than from regionalization itself.

Although Regional Health Boards were established in 1994, regionalized health care effectively began only in 1996 with the devolution of major health care responsibilities to Regional Health Boards. Thirty-four Community Health Boards have been established since then, but the status of Community Health Boards has not been established in law. The regionalized process in Nova Scotia is still in its early stages. In addition, the goals of

regionalization, which are based on building health care “from the community up,” have not been communicated clearly to the public. Key components of the regionalized system in the continuum of care, for example Home Care, Long Term Care, and tertiary care, remain outside of the regionalized health care system.

The Task Force believes that for regionalization to work as a community-based system for health care in Nova Scotia, it must be strengthened and completed. Nova Scotians in general and our urban areas in particular, have not yet had the opportunity to experience regionalized health care as it was originally conceived. The recommendations outlined below and detailed in the report are designed to support a fully integrated, community-based health care system.

## **Recommendations**

The Task Force feels strongly that these recommendations must be adopted in their entirety to address the issues outlined in this report and to give structure to a fully integrated, regionalized system.

- **Continue the Process of Regionalization**

The Task Force is convinced that regionalization must be strengthened if it is to be continued. To reverse the process at this stage would further disrupt the system, increase costs, and lead to a more fragmented system of health care.

- **Develop and Strengthen Community Health Boards**

A major step in strengthening the regionalized system will be defining in law the status of Community Health Boards. Another will be developing stronger links between Community Health Boards and Regional Health Boards by ensuring that Community Health Boards select two-thirds of the membership of the Regional Health Board. This would enact the principle of building the health care system “from the ground up,” as originally envisaged in *The Blueprint for Health System Reform* (1994).

- **Adopt a New Funding Structure for Regional Health Boards**

The Task Force recommends adopting a new funding structure under which all funding for health care services, whether delivered by devolved services or by the Provincial Health Care Centres, be channeled through the regional boards. To support this approach, a funding formula that would allocate health care dollars to the regions on a population adjusted basis should be introduced without delay.

- **Establish a Mental Health Commission**

The Task Force recommends that a Mental Health Commission be established to plan and set province-wide delivery standards for integrated mental health services by March 31, 2000.

- **Change the Status of the Non-Designated Organizations**

The Task Force recommends several important changes to integrate the four Non-Designated Organizations (NDOs) more closely into the regionalized system. These include merging the boards of the Cape Breton Healthcare Complex and the Eastern Regional Health Board to capture the strengths of both in a single Eastern Regional Health Board. In addition, the Nova Scotia Hospital should no longer hold NDO status; this facility should be integrated into a strong, province-wide plan for mental health under a proposed Mental Health Commission to be established by March 31, 2000. This would allow closer integration of all mental health services.

Because of the complexity of their service delivery, the importance of these facilities and their roles as teaching and research centres and their roles as provincial and inter-provincial referral centres, the Task Force recommends that the IWK-Grace Health Centre for Children, Women and Families, and the Queen Elizabeth II Health Sciences Centre retain their own boards. However, their activities should be more closely integrated into the regionalized system by having their delivery of primary, secondary and tertiary care services to Nova Scotians contracted for and funded by the regions.

The Task Force also recommends stronger representation of the four regional health boards on the boards of these two facilities. Because of this change in approach, the Task Force recommends these institutions be identified as Provincial Health Care Centres (PHCCs)

- **Establish a Provincial Policy and Accountability Council to Provide Leadership**

Planning and accountability within the regionalized health care system require strengthening. The Task Force recommends that the current Provincial Leadership Committee and the Provincial Advisory Council be replaced by a Provincial Planning and Accountability Council, chaired by the Deputy Minister of Health and with representation from the Regional Health Boards, Provincial Health Care Centres, the proposed Mental Health Commission, health care providers and others as required.

- **Devolve Home Care and Long Term Care to the Regional Health Boards**

The Task Force recommends devolution of responsibility for Home Care and Long Term Care to the Regional Health Boards by March 31, 2000. Long Term Care requires closer interaction between the Department of Health and the Department of Community Services. The current division of responsibility for long-term care facilities between the two departments is not in the best interest of a strong health care system.

Another deficiency in need of correction is the lack of a single-entry system for both Home Care and Long Term Care. The system should provide standardized assessment procedures. The Task Force recommends that such a system be in place by December 31, 1999.

- **Retain the Existing Boundaries for the Present**

The Task Force recognizes that some health care providers, site managers, and members of the public in some regions feel disenfranchised, most citing a loss of local authority in community hospitals, and problems of distance from regional boards. However, believing that any change in boundaries at this time would be premature, disruptive, and expensive, the Task Force does not recommend any change in the boundaries of the four health care regions for the present.

- **Strengthen the Relationships between Hospital Foundations and Regional Health Boards**

The Task Force recommends a closer cooperation between hospital foundations and regional health boards to establish priorities for fund-raising and reduce delays in implementation of foundation plans.

- **Improve Health Information Management**

The Task Force recommends that the Department of Health make a clear resource commitment to health information management, including the development of a consensus on a province-wide unique patient identifier system to track patient information across the system.

- **Develop a Long-Term Communication Plan**

The Task Force recommends that the proposed Provincial Planning and Accountability Council establish a long-term communication plan to ensure that all Nova Scotians are kept informed of the plans, successes, and challenges of health care in general, and regionalization in particular.

## Introduction

Nova Scotia's greatest natural resource is its people. All of us must work to sustain and strengthen this resource and do everything possible to maintain and improve our health by improving the efficiency and effectiveness of our health care system.

To help Nova Scotians achieve that goal, in October 1998, as a result of a Resolution passed by the House of Assembly and supported by all three political parties, the Honorable Jim Smith, Minister of Health, created a Task Force on Regionalized Health Care. Its mandate was to evaluate the status of regionalized health care in Nova Scotia in terms of the objectives of regionalization and to make recommendations for further improvement.

In evaluating the findings and preparing the recommendations that follow, the Task Force was guided by the following general objectives for regionalized health care:

- to improve the health of Nova Scotians
- to improve the quality, accessibility, and integration of health services
- to make the system more efficient and to re-direct funding to patient/client care within an integrated delivery system model
- to increase citizen involvement and accountability in health care planning and management of health care
- to promote cooperation among health care sectors and providers, thereby eliminating unnecessary duplication and gaps in service delivery
- to tailor health programs to assess local needs, emphasizing community-based delivery
- to create decentralized governance and management structures that are clear in their decision making and easy to understand

The Task Force began by consulting with regional and community health board members; health care providers, administrators, managers, and consumers; and the general public. By conducting surveys and focus groups, holding meetings, and inviting written submissions, the Task Force was able to determine the level of knowledge these groups have of the regionalized health care system and their satisfaction or dissatisfaction with the part(s) that most affected them, and to evolve their recommendations for change. The scope of the mandate was limited to regionalized health care; the Task Force did not investigate issues related to the health care system in general.

As a framework for the process, the Task Force focused on six core principles:

1. The health care system must be based on the health status and actual health needs of Nova Scotians.
2. To receive optimum consumer-centred health care, Nova Scotians require a system that delivers the best services possible, at as localized a level as possible, and that is receptive to local involvement in decision making.
3. To be sustainable, health service delivery must be cost effective.
4. Health care services must be easily accessible to the public.
5. Standards of health care must be consistent across communities and regions.
6. The recommendations either singularly or collectively cannot place the system at risk or introduce any significant disruption. These recommendations are intended to clarify and simplify Nova Scotian's understanding of the system, how to use and contribute to it.

The lack of consistent measurement data available and lack of consistency in accounting practices to assess the cost effectiveness of the regionalized health care system prevented the Task Force from making definitive recommendations on cost efficiencies. However, the recommendations on structure, management, and governance reflect the requirement to minimize duplication in service offerings, administrative systems, and management layers.

From its investigation, the Task Force has concluded that a substantial majority of the groups and individuals consulted approve of a decentralized health care system. While regionalization can provide the decentralized, community-based approach people favour, it has not done so; in fact, regionalization is viewed by many as the cause of a host of health care system problems, including downsizing and closures. A misunderstanding of regionalization is part of the problem, but a larger part is the fact that regionalization has not been fully implemented; therefore, Nova Scotians have not yet experienced the benefits of a fully integrated, community-based health care system. Such a system can only be developed if Regional Health Boards establish closer networks of communication with the communities they serve.

The recommendations in this report are based on the Task Force's belief that continuing the devolution process, empowering Community Health Boards, and reconstituting Regional Health Board membership offer solutions to many of the problems identified.

The Task Force recognizes the responsibility of elected representatives to establish public policies and to provide a budget for their implementation, based on a provincial vision. However, the Task Force believes that, particularly in the case of health care, the implementation of the policy should be free from purely partisan pressures exercised through political channels and parties.

## Background of Regionalized Health Care in Nova Scotia

Regionalization as a system for delivering integrated health services is not new and is not limited to Nova Scotia. Its national roots can be found in the five principles of comprehensiveness, universality, portability, accessibility and public administration affirmed in the Canada Health Act (1984). In Nova Scotia, plans for an integrated, community-based system began in the 1970s, but the actual process of devolving health care to Regional Health Boards began only three years ago, in 1996. The events leading up to the need to assess the current state of regionalized health care in Nova Scotia can be traced through the following chronology:

**1972** The Nova Scotia Council of Health, in a report entitled *Health Care in Nova Scotia: A New Direction for the Seventies*, recommended that

The province have five Regional Health Boards.

Community Health Boards be established to

- \* define local health needs
- \* direct and operate all health services at the community level
- \* assume the legal responsibility for health facilities and programs at the community level

**1989** The Nova Scotia Royal Commission on Health Care recommended that

3.14 the Government of Nova Scotia establish a Regional Health Authority for each of the regions defined by the task force of the Health Council and appoint the boards of these Regional Health Authorities based on a public nomination process defined in consultation with the Provincial Health Council

3.15 the Ministry of Health immediately begin the administration of health programs on the basis of these new regions by transferring to the Regional Health Authorities financial resources for the management of all health services

**1994** *Nova Scotia's Blueprint for Health System Reform*, published by the Minister's Action Committee on Health System Reform, dealt with a wide range of issues in health reform, of which regionalization was one. In summarizing the proposed new structure, the Blueprint stated:

Therefore, the highest priority of the interim Regional Health Boards should be to determine community boundaries and facilitate the establishment of Community Health Boards in the region. This should ensure that the reformed health care system is built from the community level up (p. 27).

The Blueprint also stated that the seven purposes of regionalization of health care were

1. to allow for effective community input into decision-making about health care resource allocation
2. to improve coordination and integration of health services at the community and regional levels
3. to minimize administrative and overhead costs in order to put more money toward services and programs
4. to reduce disparities among regions in access, availability, cost, and quality of health care
5. to reduce disparities in health status within and among regions
6. to develop a funding formula that responds to the health needs of the region
7. to achieve financial savings through appropriate economies of scale, reducing duplication of services and undesirable competition

**1994** Bill 95, *An Act to Establish Regional Health Boards*, received royal assent. This act set out the role of Regional Health Boards and stated in Article 8(1):

A regional health board shall, where authorized by the regulations and, after such consultation with the residents of the community or proposed community as the regional health board considers appropriate, establish community health boards.

**1995** The report *From Blueprint to Building*, Department of Health 1995, described the key initiatives in the renewal of Nova Scotia's health care system and provided a renovation schedule. Two particular statements are especially noteworthy:

1. Establishing Community Health Boards will be a priority for the Regional Health Board beginning in 1995 (p. 7).
2. In 1997, representatives from the Community Health Boards will make up most of the members on the permanent Regional Health Boards (p. 8).

**1996** The Department of Health began devolving health services to the four Regional Health Boards, (Northern, Eastern, Western, and Central), giving them responsibility for managing and delivering hospital-based services and mental health services. This occurred in a period of hospital restructuring, which included amalgamations, bed closures, and budget cuts.

**1996** The Provincial Advisory Council (PAC) and Provincial Leadership Committee (PLC) were also established. The PAC was to be responsible for strategic planning and policy development for the renewed health care system. The PLC was to coordinate province-wide business planning and collaborative problem solving. It established seven working groups to address specific priority tasks within specific time frames. The PAC was to meet quarterly or as required. The PLC was to meet monthly or as required.

**1997** Public Health and Drug Dependency services and employees were devolved to Regional Health Boards.

**1998** Responding to concerns expressed by the public about regionalization, in June 1998, the Nova Scotia House of Assembly adopted the following resolution, which was supported by all three political parties:

Therefore be it resolved that the Minister of Health immediately appoint a task force, including both health care consumers and providers, to review the current structure for health care delivery, and to recommend changes that will provide for the most efficient and effective community-based and controlled delivery of quality health care services throughout the province.

**1998** The Honourable Jim Smith, Minister of Health, gave the following mandate to the Task Force in October 1998:

*“Reporting to the Minister of Health, the purpose of the Task Force is to review and assess the current approach to regionalization in Nova Scotia, recognizing that regionalization is still very new. The Task Force will put forward recommendations, strategies and options for a regionalized health care delivery system that:*

- *values local involvement in decision-making and is responsive and accountable to local communities, including in the governance and management of hospitals*

- *ensures consistency and coordination between and across communities*
- *has appropriate, clearly-defined, distinct and mutually supportive roles and responsibilities for Community Health Boards, Regional Health Boards, Non-Designated Organizations and the Department of Health*
- *maximizes the public's access to health care services*
- *optimizes the use of public dollars spent on health care*
- *is built on appropriate health care regional boundaries"*

This report, which presents the Task Force findings and recommendations, is the response to that mandate.

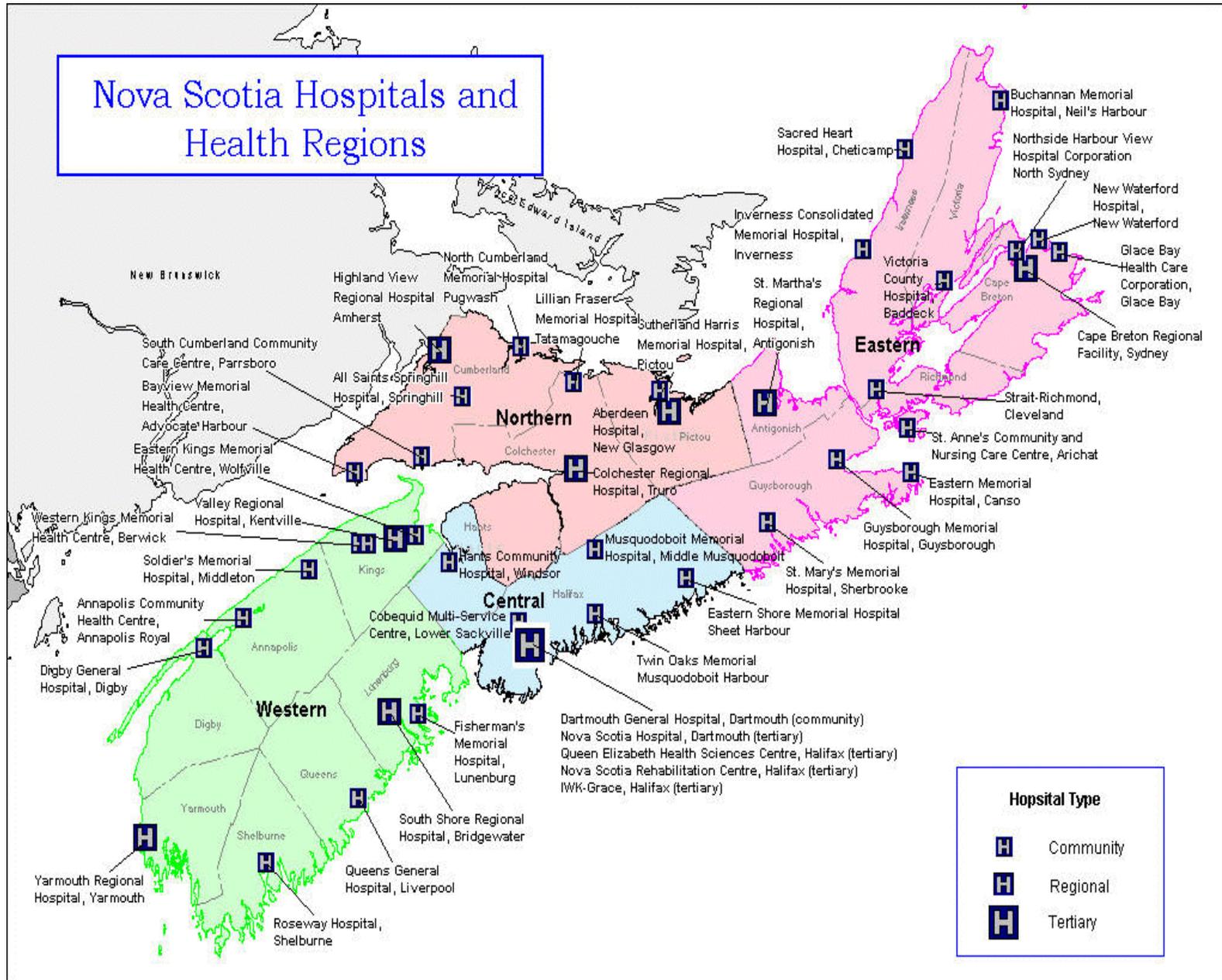
## **The Existing Structure of Regionalized Health Care in Nova Scotia**

Virtually every province in Canada has undergone some form of regionalization in an effort to improve and sustain its health care system.

In Nova Scotia, four Regional Health Boards (see the Northern, Eastern, Western, and Central regions on the map next page) were given the authority under Bill 95 to plan, manage, deliver, monitor, and evaluate health services within their region. Currently they manage and deliver hospital-based services, mental health services, public health services, and addiction services. Regional Health Boards were also given the authority to establish the first Community Health Boards, which establish the primary health care priorities for their communities and develop health plans. Regional Health Boards determine strategies and time lines for the implementation of those plans.

Currently, four hospitals remain outside the regionalized health care system. These "Non-Designated Organizations"(NDOs) are:

The IWK-Grace Health Centre for Children, Women and Families (IWK-Grace)  
The Queen Elizabeth II Health Sciences Centre (QEII)  
The Cape Breton Healthcare Complex (CBHC)  
The Nova Scotia Hospital (NSH)



## Methodology

To gather the necessary information and to develop recommendations, the Task Force sought information from Regional Health Boards, Community Health Boards and Non-Designated Organizations board members; health care providers, administrators, managers, and consumers; and the general public. The Task Force asked for responses to the following questions:

- What should be the health service delivery objectives of Nova Scotia's regionalized health care system? What recommendations should be made to advance these objectives?
- What should be the roles, responsibilities, accountabilities and inter-relationships of each of the key organizational structures in the existing system:
  - \* Regional Health Boards (RHBs)
  - \* Community Health Boards (CHBs)
  - \* Non-Designated Organizations (NDOs)
  - \* Department of Health (DOH)
- What structural or governance changes are necessary to accomplish this?
- Are Regional Health Boards appropriately representative of the local communities and key stakeholders they serve? If not, how should membership or structure of Regional Health Boards and/or Community Health Boards be changed?
- Is the current geographic delineation of health regions appropriate and efficient in terms of geographic area, population size, and manageability? Do we have the right number of Regional Health Boards and Community Health Boards now? If not, recommend changes.
- Should the approach to governance, management, and service delivery be the same in all regions? What areas, if any, require a consistent approach?
- What has been the impact of regionalization on health care delivery to Nova Scotians? What improvements can be recommended?
- Recognizing that regionalized health care service delivery is still relatively new in Nova Scotia, what have been the major obstacles or challenges thus far? What have been its major strengths?

The Task Force used several methods of gathering the information necessary to answer these questions:

***Holding Regular Meetings of the Task Force.*** Between November 1998 and June 1999, the Task Force held 30 meetings. Until April the meetings were weekly or bi-weekly. In May and June 1999, the meetings were more frequent.

Near the beginning of its mandate, the Task Force requested and received from the Department of Health information relating to the health of Nova Scotians, health care system performance, and summaries of the cost of the health care system over the past five years.

The Task Force began by defining key questions, gathering information, and identifying the various groups and individuals for consultation. By December 1998, the key methodological decisions were made, a request for public submissions had been issued, and the survey research had been commissioned.

***Conducting surveys and focus groups to solicit opinion from health board members, health care providers, health care administrators and managers, health care consumers and the general public.*** Following a public tendering process, seven proposals from consulting firms were received and Corporate Research Associates (CRA) was chosen to conduct the research. Using telephone surveys, mail-out surveys, telephone interviews, and focus groups, CRA surveyed Regional Health Board and Non-Designated Organization board members and CEOs; Community Health Board chairs and members; physicians; nurses; other acute care front-line workers; hospital site managers; long-term care administrators; home care case managers and directors; addiction and public health workers; recent health care consumers; and the general public.

Respondents were asked about their knowledge of the regionalized health care system and their satisfaction with the part or parts that had the most impact on them. They were also asked for recommendations for change. The research parameters and the results of this research are summarized in Appendix 1 of this report.

***Inviting and analyzing written submissions from advocacy and other groups, health professional organizations, health boards, and the general public.*** In late December 1998 and early January 1999, the Task Force issued a call for public submissions.

Seventy-nine submissions were received from advocacy and other groups, health professional organizations, health boards, and the general public. A complete list of the submissions and their authors is included in Appendix 2.

Task Force members reviewed each submission, discussing and classifying each of the major points in relation to the mandate questions of the Task Force. Highlights, points of consensus, and points for further discussion were noted.

The Task Force also requested and received presentations from selected health service programs (see Appendix 10).

***Holding meetings with representatives from Regional and Community Health Boards and Non-Designated Organizations.*** During May and early June, the Task Force met with the boards and senior management teams of the Regional Health Boards and the Non-Designated Organizations, and with Community Health Board representatives to ask questions and hear presentations.

***Holding public meetings.*** Public meetings were an important component of the Task Force information-gathering process. Two such meetings were held in each of the four health regions. Detailed notes were taken and used by the Task Force in developing its conclusions and recommendations.

In the final phase of the Task Force work included four facilitated day-long meetings, as a result of which the Task Force achieved consensus on key questions. When consensus was not possible, the reasons for dissent were noted.

## Findings and Recommendations

### Roles and Responsibilities

#### Community Health Boards (CHBs)

The intent of regionalization was to decentralize and integrate the health care system by developing Community Health Boards and Regional Health Boards, each having a defined role in the planning and delivery of health services. While Regional Health Boards were established in 1996, the Community Health Board development was delayed. Community Health Boards do not yet enjoy legally recognized status.

Many people who provided submissions or attended public meetings of the Task Force emphasized the lack of public input into the health care system in their area, and the transfer of responsibility for health care, and particularly responsibility for community hospitals, from communities to the Regional Health Boards. Through their hospital boards, which were made up entirely of local representatives and which provided direction for these institutions, communities had greater influence on the way their community hospital operated. The current lack of input is also seen by some as a main contributor to providers and community disenchantment with regionalization, and with other health care reform initiatives. To date, many Community Health Boards have a low public profile: the Task Force's research confirmed that only 22% of the public was aware of the existence of Community Health Boards.

In addition, the Task Force received numerous submissions from the Community Health Boards themselves and met their chairs and co-chairs during the public consultation process. The Community Health Boards struggle most with their lack of official status as representatives of the community. Communities had the expectation that regionalization would be developed "from the community up", supported by law as a vital part of health care renewal. This has not happened to date. As a result, it is perceived that Regional Health Boards have not been held accountable for their decision making. The Community Health Board members have also consistently requested that they be given the opportunity to play a significant role in the nomination of members to the Regional Health Boards. The members believe that this approach to Regional Health Board composition is the only way to ensure community-based health care planning and accountability. Community Health Board members see themselves as the voice and vehicle of choice for primary health care in the community.

The majority of Community Health Boards consulted believe they are fulfilling an important planning and advisory role for local primary health care. They also believe that when Regional Health Board membership relies more heavily on Community Health Board

nominations, the Regional Health Boards will become more accountable for implementing Community Health Plans.

The Task Force was impressed by the strength of the Community Health Boards' commitment to the health and welfare of their communities. This commitment is reflected in the fact that 24 of the 34 Community Health Boards established to date (which involve over 450 volunteer members) have already delivered Community Health Plans to their Regional Health Boards.

The Task Force recommends that:

- **the status and role of Community Health Boards be established through legislation without delay**
- **Community Health Board membership be established by a public process of election and/or nomination of 9 to 15 members**
- **Community Health Boards retain the option of appointing up to three additional members, if needed, to ensure full demographic representation**
- **Community Health Boards membership reflect the community, with health care providers represented**
- **Community Health Boards nominate members to the Regional Health Board either from the community at large or from the Community Health Board membership**
- **Community Health Boards develop primary health care plans for their communities and advise the Regional Health Board on those plans on an on going basis**
- **Community Health Boards develop community-based mechanisms to evaluate facility and program service delivery, involving members of the community, health care providers, and other stakeholders**

*Minority opinion:*

*One member of the Task Force advocated implementing a facility management structure as proposed in Nova Scotia's Blueprint for Health Reform (April 1994). The member believes that facility services require the consistent presence of an administrative and governance structure,*

*especially at the regional hospital level, to advocate on behalf of the communities served by the facility. The facility management structure proposed (Blueprint, page 43) offers communities the opportunity to monitor and evaluate facility service performance and provides an avenue for citizen input into decision making on hospital services.*

- **Community Health Boards implement community health initiatives as approved and funded by the Regional Health Board**
- **Community Health Boards encourage and support volunteer participation in health care activities at the community level, collaborating as appropriate with existing volunteer organizations**

### **Regional Health Boards (RHBs)**

Many of the submissions and presentations to the Task Force stressed that communities were unable to influence the health care services in their area and that the Regional Health Boards did not understand community needs. For regionalization to be successful, communities must have more input into decision making, and the relationship between Regional Health Boards and communities must be strengthened. Achieving these goals requires Regional Health Boards to have stronger representation from the community.

The Task Force believes that with greater representation of communities in the Regional Health Boards as a result of Community Health Board appointment of members, and with the proposed changes to the funding structure, Regional Health Boards should have the following role:

- to establish and maintain a productive working partnership with Community Health Boards
- to participate as member of the Provincial Planning and Accountability Council in defining core programs and setting standards
- to develop partnerships with the community and other public sector interests to implement preventive and health promotion programs designed to improve the health of the citizens of the region
- to develop and maintain health care and service delivery standards throughout the region

- to develop an appropriate balance among acute care, long-term care, home care, mental health services, and community-based health services delivery
- to develop a human resources plan to support regional health care programs
- to ensure optimum and appropriate allocation of health resources and minimize unnecessary duplication
- to develop community-based mechanisms involving members of the community and health care providers to evaluate facilities and program service delivery
- to develop, fund, and deliver regional health care programs

The Task Force recommends that:

- **Regional Health Boards establish and maintain Community Health Boards that are representative of the communities they serve**
- **Two-thirds (2/3) of Regional Health Board membership be made up of representatives nominated by Community Health Boards with the remaining one-third (1/3) identified by other means, for appointment by the Minister. Over the next 24 months, strategies should be developed to reconstitute Regional Health Boards progressively, ensuring that membership reflects regional demographics**

*Minority opinion:*

*Two Task Force members put forward the opinion that CHB representation be limited to a maximum of 49% of RHB voting membership to ensure that the balance of RHB composition (a majority) reflects a regional mandate for appropriate regional planning and governance.*

The majority of Task Force members proposed the following safeguards to ensure the accountability and effectiveness of Regional Health Boards:

- The meetings of the Regional Health Boards should be open to the public (except for recognized in-camera issues, as noted in Appendix 3).
- Regional Health Board membership should be selected and monitored in keeping with regional accountability, and the membership's work should reflect that accountability.

- The Department of Health should provide strong leadership to support Regional Health Boards in achieving regional goals.
- The Minister should exercise responsibility for effective management of Regional Health Boards, and as such take responsible action (including dismissing Regional Health Board members deemed to be ineffective).

### **Proposed Funding Structure**

A new funding structure is required to support appropriate devolution of authority and accountability. The Task Force believes that Regional Health Boards must become the primary administrative and management structure for both the funding and delivery of all devolved health care services at the regional level, as well as those services required from Provincial Health Care Centres. In this structure, funding from the Department of Health will flow directly to the Regional Health Boards who will then allocate funds to each service component within the region. Regional Health Boards will purchase required services from Provincial Health Care Centres. This funding process will allow the funds to follow the patient.

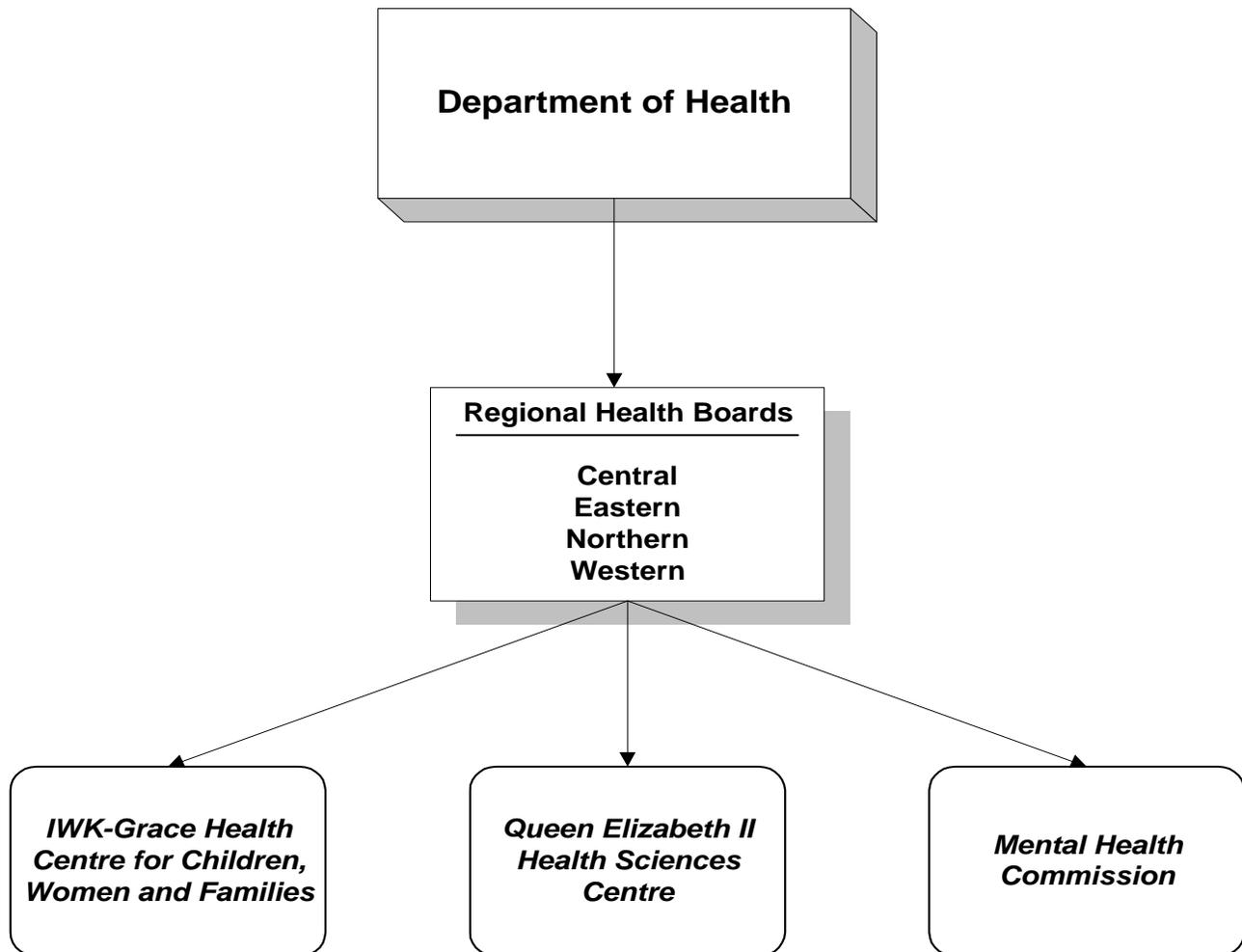
To support this proposed strategy, a population adjusted funding formula is essential. The approach should not be implemented until an appropriate and well-tested funding formula is in place. Once validated, the funding formula will assist the Regional Health Board to accept accountability for controlling operating costs and staying within budgeting guidelines.

The Task Force recommends that

- **all funding for health services provided by Regional Health Boards and the proposed Provincial Health Care Centres be allocated to the four Regional Health Boards**
- **the proposed Provincial Planning and Accountability Council (PPAC, see page 30) develop a funding formula as outlined in the report *Funding Methodology - June 1997* to be used to allocate funds from Regional Health Boards to the Provincial Health Care Centres**
- **as other programs are devolved to the regions, funding be provided to the Regional Health Boards based on the funding formula established by the proposed Provincial Planning and Accountability Council (PPAC)**

The diagram below outlines the proposed funding formula.

### Proposed Funding Structure



## Mental Health Services

Mental health services currently comprise psychiatric services, psychological services, residential (in house and group homes) and treatment facilities, mental health clinics, child and adolescent mental health services, and integrated educational programs with the Departments of Justice and Community Services.

In its review of mental health services in Nova Scotia, the Task Force found serious gaps in the services. There are insufficient resources in place to address mental health, especially regarding adolescents and children. Services are fragmented, and patient overload is a problem. Consumers and health care providers are vocal about their frustration. They advocate strongly for a provincial vision, leadership and accountability for sustainable mental health services.

An example of fragmentation is the lack of integration between mental health and addiction services in Nova Scotia. Mental health and addiction problems (such as alcohol, depression, and suicide) are inextricably intertwined. In many other jurisdictions, mental health and addiction services have already been fully integrated. The Task Force believes that an integrated approach may be in the best interests of the people of Nova Scotia.

In addition, the development of high quality, readily accessible mental health and addiction services for all citizens of Nova Scotia requires a province-wide plan delivered at the community level by the Regional Health Boards. A model for improvement at the community level can be found in the Community Mental Health Teams operating within the Halifax Regional Municipality. The delivery of mental health services at the community level should be sustained and strengthened throughout the regions. This integrated approach requires strong intersectoral leadership and collaboration unhampered by regional or institutional boundaries.

The Task Force recommends that

- **by March 31, 2000, the Department of Health establish a Mental Health Commission with a mandate to plan, develop and oversee province-wide, integrated mental health services.**

## **Mental Health Commission**

The Task Force recommends that a Mental Health Commission be established to develop policies and standards for accessible, community-based and institutional based mental health services throughout the province, and to provide leadership to service delivery elements at the regional level. The Commission should include representatives from health care providers, the Department of Health, the Regional Health Boards, tertiary care centres, the Department of Psychiatry at Dalhousie University, the Nova Scotia Hospital, consumer/advocacy groups, and Drug Dependency/Addiction Services. The Mental Health Commission will strengthen mental health services across the province, encourage better integration of services at the regional level, and enhance cooperation with other health and social agencies and other government departments.

The following suggestions are made to help the Mental Health Commission fulfil its role:

- The Deputy Minister of Health will appoint the members of the Mental Health Commission.
- The Commission will report to the Deputy Minister of Health.
- The Commission will operate with non-portable funding through Regional Health Boards.
- The Commission will determine how the role of the Nova Scotia Hospital will evolve in a regionalized system.
- The Commission will ensure appropriate resource allocation to services covering a full continuum of care, including those programs related to the social determinants of health, such as housing and justice.
- The Commission will be intersectoral, including those government departments with programs related to the social determinants of health.
- Patients' needs will determine the design and delivery of the Mental Health Services program.
- The Mental Health Services program will include preventive measures.
- The Mental Health Commission will be responsible for planning and coordinating Mental Health Services.

- The Commission will seriously consider integrating mental health and addiction services.

### **Non-Designated Organizations (NDOs)**

Four of the province's largest hospitals were excluded from the jurisdiction of Regional Health Boards. These are:

The IWK Grace Health Centre for Children, Women and Families (IWK-Grace)

The Queen Elizabeth II Health Sciences Centre (QEII)

The Cape Breton Healthcare Complex (CBHC)

The Nova Scotia Hospital (NSH)

### **The IWK Grace Health Centre for Children Women and Families The Queen Elizabeth II Health Sciences Centre**

The IWK Hospital for Children and the Salvation Army's Grace Maternity Hospital were merged in 1995. The newly created IWK-Grace facility has not been currently designated and, therefore, is not currently part of the regionalized structure.

Nevertheless it continues to provide a significant range of primary, secondary and tertiary care services to the population served by the Central region and specialized services to children from other regions. Its board includes one representative from each regional health board.

In 1995, four Halifax hospitals were merged to create the QEII: The Victoria General Hospital, The Camp Hill Medical Centre, The Nova Scotia Rehabilitation Centre, and the Cancer Treatment and Research Foundation. Similarly to the IWK-Grace, the QEII provides primary, secondary and tertiary care services to the population served by the Central region, as well as tertiary care services to the other regions. The QEII is not currently designated or placed under the jurisdiction of a Regional Health Board.

In both cases, one of the reasons why designation did not take place was that the newly formed institutions needed more time to merge their services and resources successfully before proceeding with any further reorganization.

The Task Force agreed that to achieve an integrated health care system in the province of Nova Scotia, Non-Designated Organizations cannot continue to remain outside the regionalized structure.

Research conducted by Corporate Research Associates indicated no consensus on the future status of the Non-Designated Organizations. Based on opinions from health care leaders, submissions, and presentations, the Task Force came to the conclusion that they should be further integrated into the regionalized health system. Non-Designated

Organizations are generally reluctant or opposed to being designated under Regional Health Boards. However, the Task Force believes that for a fully integrated health care system to be developed, the Non-Designated Organizations cannot exist as they do today. At the same time, the Task Force also believes that the particular circumstances of each of the four Non-Designated Organizations requires individual consideration and specific recommendations.

Structural, governance, and management changes will be required of both the Regional Health Boards and of the QEII and IWK-Grace as changes take place in funding, in tertiary care delivery throughout the province, and in primary and secondary care delivery for the Central Region. The funding accountability of the Regional Health Boards will have significant implications for the function and management of the QEII and IWK-Grace; these institutions will become suppliers to the regions instead of being independently funded as in the present arrangement.

The Task Force recommends that:

- **the term “Non-Designated Organization” be discarded in favor of the term “Provincial Health Care Centre” (PHCC), and that this designation be applied to the IWK-Grace and to the QEII**
- **regions should be enabled to contract their primary, secondary, and tertiary health services from the IWK-Grace and QEII**
- **while all regions have the capability to acquire all levels of service from IWK-Grace and QEII, the Northern, Eastern, and Western regions will contract their tertiary care primarily from these institutions. Due to its geographic location, the Central region will contract with these two facilities to continue their receipt of primary, secondary, and tertiary care services**
- **each Provincial Health Care Centre collaborate with the proposed Provincial Planning and Accountability Council to plan and coordinate the tertiary care services each will provide**
- **as with Regional Health Boards, the Provincial Health Care Centres be accountable to the Department of Health for standards and program quality**
- **the IWK-Grace and QEII each maintain its own Board of Directors; however, each of these boards should include strong Regional Health Board representation (such as two members from each region)**

### **Cape Breton Healthcare Complex (CBHC)**

The Cape Breton Healthcare Complex was created in 1996 from a merger of four facilities in Industrial Cape Breton: the Glace Bay Healthcare Complex, the Northside Harbourview Hospital, the New Waterford Consolidated Hospital, and the Cape Breton Regional Hospital. That merger took place in stages over a number of years.

To allow the CBHC to focus on the challenge of amalgamation of its four facilities in Industrial Cape Breton, the CBHC's designation to the Eastern Regional Health Board was deferred until the merged facilities were able to align services and resources under a single organizational structure.

Accordingly, CBHC currently exists as an acute care organization outside the regionalized structure. Since the CBHC's designation was deferred, no Community Health Boards have been developed in Industrial Cape Breton. The Task Force recognizes that a truly integrated system in the Eastern region can only be developed if the CBHC is fully integrated into the continuum of care across the entire region, as was originally envisaged for regionalization across the province. Therefore, Task Force members agreed that Non-Designated Organization status is no longer appropriate for the Cape Breton Healthcare Complex.

At the same time, the Task Force acknowledges the major accomplishments achieved by the administration and staff of the CBHC. Examples include their successful amalgamation of four facilities with defined roles under a single administration; their record of physician recruitment; their establishment of a cancer treatment centre and other specialized services. It is important that any changes in the status of the CBHC that are designed to support regionalization should strengthen these efforts.

While the Task Force discussed the option of subdividing the Eastern region, the majority of members believed that any such division at this stage in the regionalization process might jeopardize the Eastern region itself, and might generate initiatives elsewhere in the province to subdivide all regions.

The Task Force recommends that

- **the Cape Breton Healthcare Complex no longer maintain the status of a Non-Designated Organization**

- **the boards of the Eastern Regional Health Board and the Cape Breton Healthcare Complex merge and evolve into a single board of manageable size that includes appropriate demographic representation and retains the strength and vision of those individuals who have provided valuable leadership on each board**

*Minority opinion:*

*Two Task Force members put forward the option of creating another region in the Industrial Cape Breton area to provide specific organizational focus on developing community and public sector partnerships in an area with the most significant and deteriorating socio-economic conditions in the province. Consistent with the goal of developing an integrated delivery system based on a determinants of health approach, a region comprising Cape Breton and Victoria Counties was proposed that would adopt existing provincial regional school board boundaries (six regions) for health board governance and management. The resulting structure in Industrial Cape Breton would create a geographic community of interest among significant public sector partners, including health, education, and Human Resources Development Canada, and encourage the development of intersectoral partnerships.*

## **The Nova Scotia Hospital (NSH)**

The Nova Scotia Hospital is the provincial psychiatric and forensic facility. It was excluded from the regionalization system because of the particular services it provides and its long-standing status as an agency of the provincial government. Staff of the Nova Scotia Hospital are civil servants, and the hospital is dependent on other provincial government departments for support services.

Mental health service delivery in general, and the Nova Scotia Hospital in particular, pose some very distinct considerations for the Task Force. The Nova Scotia Hospital has focused on developing relationships and partnerships with mental health stakeholders in all regions, but there is still very little communication among the regions on mental health issues.

The Task Force believes that the role of the Nova Scotia Hospital inside the mental health system needs to be clarified in terms of its relationship with the regionally delivered mental health system.

Allowing the Nova Scotia Hospital to continue as a Non Designated Organization would not support the needed further integration of mental health services. On the other hand, simply devolving the Nova Scotia Hospital to the Central Regional Health Board would not be appropriate given the hospital's significant provincial role.

The Task Force recommends that

- **the Nova Scotia Hospital no longer maintain the status of a Non-Designated Organization**
- **a process be implemented immediately to remove the Nova Scotia Hospital from its status as a civil service institution**
- **the Nova Scotia Hospital be brought under the governance and administration of the regionalized health care system through the establishment of the proposed provincial Mental Health Commission**

## **Provincial Support and Leadership**

Two committees established in 1996 were designed to provide leadership to the regionalized health care system: the Provincial Advisory Council and the Provincial Leadership Committee.

***The Provincial Advisory Council (PAC).*** The Provincial Advisory Council is composed of the Chairs and CEOs of the four Regional Health Boards and the four Non-Designated Organizations. It is chaired by the Minister of Health. The Council meets on an *ad hoc* basis, on a quarterly basis, or as required. Its mandate includes developing the vision, strategic planning, and policies for the renewed health system.

***The Provincial Leadership Committee (PLC).*** The Provincial Leadership Committee is composed of the CEOs of the four Regional Health Boards and the four Non-Designated Organizations. It is chaired by the Deputy Minister of Health. The Committee meets monthly or as required. Its mandate includes joint health services business planning, collaborative problem solving, and joint initiatives for effective and efficient health system management. The PLC establishes working groups and subcommittees in a variety of clinical and administrative areas. The memberships of these groups are drawn from the nine organizations represented at the PLC, as well as from other relevant health system organizations.

The Task Force gained the impression that the PAC and PLC do not currently provide the strength and strategic leadership required for top-level, province-wide health system planning. Strong vision and leadership are required to promote health system development. In particular, continued development and maintenance of a regionalized health care system requires consistent direction over time. This calls for a collaborative, coordinating body of high-level decision makers and strategists to support each component of the system..

The Task Force recommends that:

- **the Provincial Advisory Council and the Provincial Leadership Committee be replaced by a Provincial Planning and Accountability Council (PPAC), to be established as the primary planning mechanism for the health care system with respect to the following functions:**
  - \* **identifying and planning core services**
  - \* **setting standards for health care and health service delivery**
  - \* **monitoring and evaluating performance of regional and provincial programs**
  - \* **considering options for achieving greater cost efficiency, particularly in areas such as purchasing and administrative services**
  - \* **establishing task-specific committees as necessary**
  - \* **develop and implement a strategy to prevent operating deficits at the Regional Health Board and Provincial Health Care Centres level**
- **the Deputy Minister of Health chair the Provincial Planning and Accountability Council**
- **Provincial Planning and Accountability Council membership consist of:**
  - \* **the Chair and CEO, or their designate, of Regional Health Boards, Provincial Health Care Centres, Mental Health Commission, and Nova Scotia Hospital (until its future role is defined)**
  - \* **a representative of emergency medical services**
  - \* **a representative of Home Care and of Long Term Care (until those services are devolved)**
  - \* **representation, as required, from health providers and from the following government departments: Community Services, Justice, Housing and Municipal Affairs; and representatives from the Senior Citizens' Secretariat (for social determinant integration).**

*Minority Opinion*

*One member of the Task Force expressed that physician representation should be included in the membership of the Provincial Planning and Accountability Council. This committee is responsible for developing health care standards and planning core services, and therefore the expertise of physicians is essential*

## **The Department of Health (DOH)**

In submissions received and consultations held throughout the province, the Task Force heard from consumers, health care providers, and the public that standards for health care and health services delivery are applied inconsistently throughout the province.

The Department of Health is seen as the appropriate component of the health system to establish both health policy and clear standards for health care and health services delivery. As well, stakeholders expect the Department of Health to monitor the performance of the health system and to provide leadership to regions to ensure appropriate standards of care and service delivery.

The Task Force recommends that the role of the Department of Health should be

- to establish health policy and to collaborate with the Provincial Planning and Accountability Council in setting provincial standards for health care and health services delivery
- to monitor the performance of the health care system in terms of care delivery and outcomes achieved
- to provide leadership and support to regions, tertiary care, and provincial programs in meeting Nova Scotia's health goals
- to provide adequate funding to the health system
- to develop a provincial human resource plan for physicians with appropriate consultation
- to support research initiatives aimed at improving the health of Nova Scotians

## **Home Care and Long Term Care.....Continuing Care**

“Continuing care” is a term used to describe a system of integrated service delivery which includes long term institutional care, home support services, home care, and a variety of alternative living arrangements in the community. Currently, many of these programs and services are delivered to Nova Scotians in relative isolation from one another, under different government departmental authorities, with different budgets and funding mechanisms, and in a variety of settings.

“Continuing care” involves a continuation of care in two dimensions – over time and across service components. It is not a single type of service but a complex system of service delivery which has discrete components. In response to the needs of its clients, continuing care is multi-faceted and combines aspects of both health and social services.

Regionalization was intended to provide the necessary structural supports for the building of an integrated system for Nova Scotians. Based on its findings, however, the Task Force has concluded that neither the necessary structures nor the integrating mechanisms are in place to build a fully functional system that is inclusive of continuing care.

Home Care Nova Scotia is still planned and delivered by the Department of Health. Responsibility for the Long Term Care sector is divided between the Department of Health and the Department of Community Services. Both of these components of continuing care remain outside the regionalized system, despite the recommendations of several earlier reports and despite the building pressures from the acute care sector for more timely and appropriate access to placements in the continuing care sector.

Unlike every other province in Canada, Nova Scotia still has no system or mechanism for a single entry mechanism for clients requiring these chronic care services. In its survey work, its presentations, and its face-to-face meetings, the Task Force was urged by representatives of the home care, long term care and acute care sectors to recommend the creation of a single entry mechanism for continuing care.

Single entry, coordinated assessment, and case management have shown in other provinces to increase both the efficiency and effectiveness of continuing care service delivery. Without single entry, Nova Scotians sometimes have to go to a variety of persons or organizations to find out what is available, how to access it, and what might be best in their particular circumstance. Single entry provides “one-stop shopping” so that clients and their families do not have to navigate the system on their own. Other advantages of single entry include:

- ▶ consistent and accurate information available to clients and families at the point of intake to the continuing care system
- ▶ minimization in the duplication of management, excessive cost, and inconsistency of service
- ▶ easily managed client movement across program lines in response to needs
- ▶ standardization of access criteria applied uniformly across the province, regardless of the intake point.

The Task Force recommends that:

- **Home Care be devolved to the Regional Health Boards by March 31, 2000.**
- **Funding for Long Term Care be devolved to the Regional Health Boards by March 31, 2000.**

- **Regional Health Boards enter into contractual arrangements with Long Term Care organizations to ensure a smooth transition of services and responsibilities.**
- **A system of single entry access to continuing care services be established by December 31, 1999. The single entry system should be developed in partnership with provider organizations within the continuing care sector, ensuring that decision-making is based on a standardized assessment and reflects the values and vision of the sector, its clients and their families.**

## **Boundaries**

One of the Task Force's most significant challenges has been the interpretation of data and feedback regarding regional boundaries and the appropriate size of regions. A consistent theme in the presentations and submissions was the lack of community and health provider input into regional decision making. Communities and providers feel considerably disenfranchised because of regional boards and management. Many characterize Regional Health Boards as another bureaucratic layer in the health system and cite delayed decision making and protracted travel time as the realities of a "distant" governance and management structure. Research conducted for the Task Force indicates that these same groups are also concerned that regions may be too big to understand and address needs at the community level.

The Task Force believes that many concerns of health care providers, and of the public, arise from changes in their opportunities to provide advice and have influence in decision-making rather than from the size of the regions as such.

The Task Force found a general acceptance of the notion of community-based health care planning and service delivery and an understanding that the system cannot go back to where it was before regionalization. However, no general agreement was found regarding the appropriate size of the regions for governance and management of health services delivery.

At this time, the Task Force does not recommend specific changes to boundaries. Further subdivision of the province into more regions, or amalgamation to create larger regions, is fraught with the likelihood of creating greater confusion. It should be noted that all Regional Health Boards recommended that regional boundaries remain as currently delineated. Some Regional Health Boards are convinced that recarving the province into smaller regions is not in the best interests of developing intersectoral integration at the community level and carries the risk that the system will slide back into a facility-based orientation.

The Task Force concludes that every effort should be made to continue the devolution process, to empower Community Health Boards, and reconstitute Regional Health Board composition before taking any steps toward boundary change.

Another area of obvious confusion among stakeholders (and experienced to some extent by the Task Force itself) concerns the organizational structures within the regions. Each region has chosen its own management structure, and significant differences can be found among them all. The Task Force was advised that organizational structures have been developed in keeping with the priorities and program challenges of each region. The Task Force has therefore concluded that further consideration is required before any recommendation can be made concerning consistency of organizational structures among regions.

The Task Force believes, however, that the proposed Provincial Planning and Accountability Council should review this issue.

- **The Task Force recommends that regional boundaries remain the same for the present**

*Minority opinion:*

*Two Task Force members put forward the option of adopting existing provincial regional school board boundaries (six regions) for health board governance/management. The resulting structures will begin to create common geographic communities of interest among significant public sector partners and facilitate intersectoral cooperation necessary for implementing a social determinants of health approach to health care management.*

## **Regional and Community Hospitals**

During the public consultation process and in its research, the Task Force received considerable feedback regarding facilities. Facilities have traditionally had critical significance for citizens. They are seen as central to the provision of health care services at the community level. Citizens tend to equate the number of beds in their communities with quality of care. Citizens in every region identified changes in facility management and services as difficult to accept. They consistently asked that further reductions in facility-based services be halted.

Another consistent area of concern is a perceived lack of autonomy at the facility level. Health care providers, site managers, and the public generally believe that their community facilities have lost their significance in the regionalized management structure. Many perceive that the communities in which facilities have been developed are “out of the loop” in regional planning and decision making. Members of the public consistently state that they no longer know who is in charge and whom to contact with their concerns.

As well, communities believe that facilities cannot be administered from a distance and question the ability of distant regional managers to understand and appreciate their facilities and the extent to which citizens rely on them for health care.

The public and providers query the actual role played by site managers, whom they perceive as having little real authority in administering facilities. Feedback from site managers suggests that they are not sufficiently respected as influential in the regional scheme (see Appendix 1). At the same time, while site managers do attempt to characterize regionalization positively, they are vague in identifying actual improvements to date in health care delivery.

The Task Force believes that the impact of regionalized governance and management on facilities has been underestimated as regionalization has been established. Unfortunately, this has resulted in significant disillusionment at the community, provider, and site management level. Health care facilities play an important role in the day-to-day operations of health services delivery and are regarded by communities as a critical component in the continuum of care. Communities fear that facilities are being devalued in the health reform process.

The Task Force recommends that

- **Regional Health Boards carry out management audits by December 31, 1999, to assess current practices and to recommend improvements pertaining to facility and communication management, and community development in a regionalized setting**
- **every acute care facility designate an individual who is on site to address day-to-day issues and concerns**
- **site managers be given sufficient authority to make day-to-day operating decisions within the established parameters of Regional Health Boards Policies and Procedures**
- **stronger mechanisms be introduced to ensure consistent communication and involvement in decision making between site managers and Regional Health Boards**

## Hospital Foundations and Volunteerism

Encouraging and expanding community support, both financial and voluntary, are essential to the Canadian health care system. Regionalization has, understandably, created some degree of anxiety and confusion in community health care foundations and in the voluntary sector.

The perception that Regional Health Boards are distant from communities and represent a centralized agency has hindered fund-raising. Decision making has taken too long in cases where foundations identified a specific reason for a campaign. In some cases, there has been a long delay between raising money and receiving approval to spend it.

Foundations have traditionally focused their fund-raising efforts on physical facilities (community hospitals) and on funding the purchase of major equipment items. Despite the designation of regional and community hospitals to Regional Health Boards, many donors wish to direct their contributions toward the community facilities upon which they have traditionally depended for service.

In some regions, it is clear that communication between foundations and Regional Health Boards has been inadequate. As one foundation representative put it, "We are disappointed with the difficulty of communicating with the Regional Health Board; we don't know where we fit."

Frustration was also expressed about the length of waiting time for decisions from the Regional Health Boards. Formal communication mechanisms must be established to ensure a productive working partnership and community of purpose between foundations and Regional Health Boards.

Other identified needs include the following:

- Foundations and Regional Health Boards should agree on local needs before foundations begin targeted fund-raising.
- Regional Health Boards must develop a clear and well-publicized statement on hospital bequests and donations, one that both protects the wishes of donors and meets approved local needs. Money that the Regional Health Boards receive from donations should be returned to foundations immediately if it is clear that the money given is intended for specific hospitals.
- Good health care shall extend beyond the walls of institutions. To ensure a productive working partnership among Regional Health Boards, auxiliaries, and foundations, a positive communication mechanism is essential.

The Task Force recommends that

- **where this has not already occurred, Regional Health Boards and hospital foundations should immediately establish a mechanism for regular meetings to develop agreed-upon priorities for voluntary fund-raising consistent with the regional mandate, community health plans, and donor preferences.**

## **Volunteers**

As with foundations, community participation in health care by volunteers and auxiliaries has traditionally focused on community hospitals and other institutional sites, and has often involved volunteers working directly with patients. Some respondents indicated that with regionalization and loss of hospital autonomy, recruiting and retaining volunteers has become more difficult.

The Task Force learned that some Community Health Boards (themselves composed entirely of volunteers) have been remarkably successful in recruiting volunteers from the community to support new health care services that the volunteers themselves identified as priorities and championed. Extending the focus of volunteer participation beyond the confines of hospitals is critical to the success of a reformed, regionalized health care system.

## **Health Charities**

Nine of the major provincial health charities compose the Health Charities Network<sup>1</sup> of Nova Scotia, which mandate includes research, education, and service support. One of the submissions received stated that “regionalization has created several more layers of bureaucracy for provincial health charities. Whereas previously the opportunity existed to communicate with the Department of Health at one entry point, there are now four regions with whom the health charities must build new relationships and establish new communication links. The creation of community health boards has added a further challenge.”

The Task Force recommends that

- **the Department of Health and the Regional Health Boards explore a mechanism to formalize a relationship with health charities.**

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<sup>1</sup>Heart and Stroke Foundation, Canadian Cancer Society, Canadian Diabetes Assoc., Multiple Sclerosis Society, Alzheimer's Society, The Lung Association, The Arthritis Society, Muscular Dystrophy Association and Mental Health Association.

## **Information Management**

Before regionalization and with few exceptions, health care organizations in Nova Scotia were not heavily dependent on computers and related communication systems for collecting and analyzing data or for disseminating the information produced. Province-wide information to support funding decisions, the development of performance indicators, and annual financial planning was collected by a combination of manual and electronic means. With regionalization, such an approach is no longer practical. This is due to the increased number of often-incompatible systems, many still relying on manual effort.

In addition, few systems are available to help health care providers within health facilities track patient information, and fewer still can track patient progress between institutions as treatment progresses from the primary or secondary level to tertiary care. If decisions on how to improve the health care system and the treatment patients receive are to be soundly based, accurate information produced in a timely and efficient way is essential. The most obvious way this can be achieved is through increased investment in information technology (IT).

In recognition of this, in 1996 the provincial Information Management Steering Committee (IMSC) was set up as a subcommittee of the Provincial Leadership Committee (PLC). Its membership consists of representatives from the Department of Health, the four regions, and the Non-Designated Organizations.

Its mandate is to recommend solutions that will support the concept of a province-wide health information network. Its objectives include preparing and maintaining a plan for an integrated, province-wide health information system that will ensure consistent standards throughout while minimizing data duplication and maximizing information sharing. A policy framework will ensure the security, privacy, and confidentiality of the data collected, the information generated, and the technical resources used.

From the outset, it was clear to the Task Force that those making submissions were limited in their ability to support their material with statistical or numerical data. This data either had not been collected due to the effort required or had been collected using incompatible means over different time periods. Health care providers highlighted the problem of tracking patient information and progress when each institution, and often individual departments within a given institution, has its own unique identifier for those patients. Integration of services is one of the goals for the health care system. Without the integration of, and ready access to, standardized administrative and patient data across the system, the full benefits of service integration will remain elusive.

The Task Force recommends that

- **the Department of Health make a clear resource commitment to health information management and to the necessary supporting and integrated infrastructure across the health care system**
- **consensus on a unique, province-wide patient identifier system within the information management system be reached among all stakeholders**

## **Communication**

It is now clear that in planning and implementing a regionalized health care system in Nova Scotia, the importance of effective communication, both with the people of Nova Scotia and within the health care system, was grossly underestimated.

The Task Force's research identified major communication problems. Deficiencies in communication heightened the angst of providers and stakeholders concerning regionalization and may have adversely affected the successful implementation of a regionalized health care system.

Consumers, the largest and most important group of stakeholders, seemed, on the whole, unaware of what regionalization is, and are unclear about its purpose. Similarly, health care providers identified a lack of communication about roles, accountability and responsibility, and about the achievements of regionalization.

Many, incorrectly, assumed that the main purpose of regionalization was to cut costs. Regionalization has, therefore, become a readily available scapegoat for the perceived shortcomings of the health care system.

Most provider groups stressed the need for better communication. As one respondent put it, "when the regionalization train left the station it left the public and the physicians behind." There is a need for vastly improved communication within and among all levels of the regionalized health care system if further steps in the process are to be successful. The issue of communication is not one of developing a propaganda-type sales pitch for regionalization. It is more specifically a matter of keeping all stakeholders well informed about plans, successes, and problems needing solution.

The Task Force recommends that

- **through the proposed Provincial Planning and Accountability Council, a long-term communication plan be developed to inform Nova Scotians about the goals, accomplishments, and challenges of health care in general and regionalization in particular**
- **Regional Health Board and Community Health Board meetings be open to the public, except when dealing with issues customarily dealt with in-camera (e.g., personnel issues—see Appendix 3), beginning September 1, 1999**
- **public awareness of and degree of satisfaction with the regionalized system be documented periodically, using valid survey methods; the results should be used by Regional Health Boards to improve communication and to publish accomplishments for public evaluation**

## Conclusion

In fulfilling its mandate, the Task Force has consulted widely with and listened attentively to the many views that were put forward by the public, by various organizations, and by health care administrators and health care providers. From the views expressed, it was evident that a substantial majority favour a decentralized approach to the delivery of health care services, one that clearly takes into account local needs and that can respond readily as these needs evolve. Regionalization continues to be, in our view, an approach that can meet this requirement. However, as regionalization has not been completed, with only a limited number of health care services transferred to date to the regions, the people of Nova Scotia have not had the opportunity to experience a truly regionalized and integrated system that provides coordinated care as patients move through the system. Our recommendations address these issues.

The need to increase local involvement in the overall planning and direction of health care at the community level was clear. This is a priority. Community Health Boards are already making a significant contribution in this direction. Once strengthened as recommended in this report, their approach to the task within a broadened regional system will be more consistent and their participation more direct.

Access to health care services was an important issue for many people. Mental health services were frequently referred to as difficult to locate and access. Waiting times for service were seen as barriers to receiving health care services. On the other hand, some improvements in selected programs were referred to on a number of occasions. The recommendations in this report are intended to improve access to a wide range of services and better use of public funds for health care.

Overall, the Task Force concludes that the regionalization process cannot continue in its current incomplete form. Only by building on the regionalization initiatives taken to date can Nova Scotians experience the benefits of a fully developed, community-based health care system. The recommendations included in this report give the necessary structure for meeting that goal. Implementing the recommendations in their entirety will require strong leadership and commitment from all the decision makers involved.

The Task Force believes that implementation of its recommendations will strengthen regionalization and improve the health care system for Nova Scotians. The health care system cannot go back to its pre-regionalization structure which did not facilitate community involvement or accountability closer to the communities served.

**Appendices**  
**Report of the Minister's Task Force on Regionalized  
Health Care in Nova Scotia**

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1. Stakeholder Input on Regionalized Health Care in Nova Scotia (Corporate Research Associates)
2. Written Submissions to the Minister's Task Force on Regionalized Health Care
3. "In-Camera" sessions
4. Regionalized Structures and their Responsibilities in Health Systems Across Canada
5. Terms of Reference of the Minister's Task Force on Regionalized Health Care
6. Work Plan of the Minister's Task Force on Regionalized Health Care
7. Documents and Reports Reviewed by the Minister's Task Force on Regionalized Health Care
8. Consultants Retained by the Minister's s Task Force on Regionalized Health Care
9. Meetings with stakeholders held by the Minister's Task Force on Regionalized Health Care
10. Presentations to the Minister's Task Force on Regionalized Health Care
11. Biographical Sketch of the Members of the Minister's s Task Force on Regionalized Health Care
12. Department of Health Staff Support for the Minister's s Task Force on Regionalized Health Care

# Stakeholder Input on Regionalized Health Care in Nova Scotia

## All Stakeholders

### *Final Report*

*Prepared for the:*

**Minister's Task Force on Regionalized Health Care  
in Nova Scotia**

**June 1999**

C O R P O R A T E R E S E A R C H  
A S S O C I A T E S I N C 

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# Introduction

## Background

In Nova Scotia (and across Canada), health care is in a state of profound transition as governments and health-care institutions strive to reduce costs, improve efficiencies and cope with the changing composition and expectations of citizens. In 1993, the Province initiated a major reform of the health care system “to promote, maintain and improve the health status of Nova Scotians at a cost that is sustainable for Nova Scotia.” One of the cornerstones of health care reform in Nova Scotia has been the “regionalization” of the health system, following passage of the Regional Health Board Act in 1994.

The goal of regionalization is to move the planning and delivery of health care services closer to the consumer, thereby providing client-focused high-quality services in a more accountable and cost-effective way. This system is organized around four regional health boards (RHBs) which oversee and manage designated hospital facilities and related services, plus four “non-designated” hospitals (NDOs) which serve a province-wide role in the health care system (e.g. IWK-Grace Health Centre). Community Health Boards (CHBs) have also been established to support RHBs in the development of local community health plans.

In November 1998, the Minister of Health established a special Task Force to evaluate the regionalized health care system in Nova Scotia, and provide recommendations for strategies and options to ensure the system meets key principles such as valuing local involvement, ensuring consistency across communities and regions, maximizing public access, providing an appropriate structure, and being cost effective. To fulfill this mandate, the Task Force retained Corporate Research Associates Inc. to provide assistance in collecting the opinions and experiences of key stakeholder groups across the province in terms of the impacts and consequences of the regionalized approach.

## Research Objectives

The overall purpose of the research is to conduct and report on research directed at obtaining relevant information from key stakeholders in the regional health care system across the province. This report presents the key findings and conclusions across all of the stakeholder groups covered in this research. A list of these groups is presented below, along with the research methodology used with each group. A separate more detailed report on the research conducted with each of these groups has been prepared as supporting documentation for the Task Force (see Appendix A).

### Research Parameters

Stakeholder Group	Method	Research Parameters
<b>A. Health Boards</b>		
1. RHBs/NDOs	Quantitative - Telephone Survey	Representative sample of 66 Board members
2. CHBs	Quantitative - Telephone Survey	Representative sample of 130 Board members
<b>B. Service Providers</b>		
1. Acute Care Facility Senior Management	Qualitative – In-depth Interviews	Telephone interviews with 6 site managers
	Quantitative – Telephone Survey	Telephone survey with 28 site managers
2. Nurses	Qualitative – Focus Groups - In-depth Interview	4 groups – 1 location per region Telephone interviews with 2 nurse/managers
	Quantitative – Telephone Survey	Representative sample of 301 nurses
3. Physicians	Qualitative – Focus Groups	4 groups – 1 per region
	Quantitative – Mail-out Self-administered Survey	Completed surveys received from 345 physicians
4. Acute Care Facility Front-line Staff	Quantitative – Telephone Survey	Representative sample of 204 front-line staff
5. Long-term Care Facility Management	Quantitative – Telephone Survey	Representative sample of 50 facility managers
6. Home Care Workers	Quantitative – Telephone Survey	Representative sample of 79 admin. care coordination staff
7. Addiction/Public Health Workers	Quantitative – Telephone Survey	Representative sample of 76 addiction services and public health staff
<b>C. Public/Consumers</b>		
1. Nova Scotians 18 years plus	Quantitative - Telephone Survey	Representative sample of 800 Nova Scotians ( <i>CRA Atlantic Omnibus Survey</i> )
	Qualitative - Focus Groups	4 Groups - 1 per region

## Executive Summary

This is a difficult point in time to be evaluating regionalization. On one hand, it is valuable to know what must be done to improve regionalization's success. On the other hand, regionalization's implementation is relatively recent in terms of being able to evaluate whether it is working and to what extent it is achieving its goals. As well, there are other issues which no doubt distort stakeholders' perceptions and opinions, in particular strained financial and human resources.

Notwithstanding the inherent difficulty of evaluating whether regionalization is successful, the research shows that in general, there is neutral to positive support for the goals of regionalization and for the conceptual framework underlying it. This general finding should be taken with caution, however, since it is one thing to agree with the concept, and another to feel regionalization is proceeding as it should. Indeed, physicians seem just as ready to dismantle regionalization approach and revert back to the prior model as they are to proceed with making it work. Reactions to regionalization and its implementation are much more positive among those providing administration and governance than by stakeholders providing care. Consumers, arguably the most important and certainly the largest stakeholder group, are on the whole ignorant of regionalization, that it has been implemented, and its ramifications for Nova Scotians. So, while there is relatively firm support for the idea of regionalization, there also exists a significant stakeholder population which either explicitly does not support it, or due to their low awareness, cannot truly be seen to support it.

Of all the stakeholder groups, Board members and site managers are the most positive in the degree to which regionalization is meeting its goals. In particular, process goals such as increasing citizen involvement and increasing cooperation among stakeholders are viewed as having experienced some progress. There is a split of opinion about other process-related goals, with non-provider stakeholders believing progress has been made, and provider groups indicating regionalization has done little to further their cause.

This split is similar to stakeholders' opinions of the degree to which patient-outcome goals are being reached. Notwithstanding that many stakeholders feel it is too soon for them to evaluate regionalization's effect on outcome goals, non-providers are much more likely to see progress being made in these areas, although even here there is less certainty they have seen improvements in access to care and other such goals. Providers and consumers offer a very different perspective, on the whole disparaging the effect that regionalization has had on the quality and access to health care available to Nova Scotians.

The differences in perspectives should not be taken solely on their face value. Health care providers have an issue with what they see as a dearth of communication about roles,

about accountability and responsibility and about successes. In short, they want to know what is happening and to feel they are a part of the process. The observed split in stakeholders' opinions suggests an absence of communications activities has constrained their optimism in the face of massive change.

Based on stakeholders' opinions, successful implementation will require more human and financial resources will be required. This is seen to be a large barrier to the implementation of any new process, regardless of whether it is regionalization or some other system.

An equally large issue among stakeholders is the limited extent to which RHBs are receiving and using input from other stakeholder groups across the province. While Regional Health Boards seem to feel they are getting and using information appropriately, others do not share this perspective. Site managers feel that, although RHBs are the right place for many decisions, they themselves are sometimes left without the ability to make the decisions needed to run their facilities on a more operational level. Others feel the current regional process does not allow enough input from providers or from facilities, thus eliminating one of the more important tenets on which regionalization was founded. The size of the regions, while not an over-whelming concern, is seen to exacerbate the difficulty of RHBs identifying communities' needs. These concerns prompt the call for stronger stakeholder representation on Regional and NDO Boards.

Clarifying the roles of the governing bodies, (the Department of Health, the CHBs, the NDOs and the RHBs) will certainly be required. Currently, there is limited understanding or agreement about which level of the system should have the primary role for the many areas of health care planning and delivery. Except for a recognition that CHBs should be responsible for primary care activities and the province taking the lead on Pharmacare and setting standards for patient care, stakeholders are divided on how the various roles and responsibilities should be assigned. This is likely causing the perception, or even the reality, of extreme disorganization which is seen to hinder the effectiveness of using existing resources.

There is limited support for the NDOs to be regionalized or designated under a Regional Board; as stakeholders recognize the distinct role they play as tertiary facilities. However, stakeholders endorse the notion that NDOs need better integration with the regionalized system so that long term planning leading to better patient care can be facilitated.

Many stakeholders seem hopeful that the review will result in something constructive, something that will help the delivery of quality health care in Nova Scotia. As might be expected, they will be carefully watching to see what the Task Force concludes and how its recommendations will be implemented.

## **Key Findings**

## **The Concept of Regionalization**

By and large, most stakeholder groups consulted for this research project were relatively supportive or neutral about the concept of regionalization. On one level, it is hardly surprising that stakeholders were found to be relatively supportive of regionalization on a theoretical level; it would be hard to disagree or find fault with goals as lofty as those put forward for regionalization. On a different level, though, it does appear that stakeholders agree the health care system in Nova Scotia needed reform. As regionalization was intended to facilitate reform, stakeholders generally seemed to endorse the idea behind it, and also endorse its intended structure.

Stakeholder groups responded to the conceptual underpinnings of regionalization differently. Health Board members, and CHB members in particular, were the most positive about the anticipated benefits likely to come from regionalization. Nurses and site managers were only slightly more positive than neutral about this approach to reform.

Moving to the less positive end of the continuum, some NDO Board members and many physicians were ready to question whether the concept of regionalization was appropriate for Nova Scotia given its relatively small population and density. Of all the stakeholder groups, physicians seemed ready to revert to a different system altogether, even to the previous one. Other provider groups (acute care front line staff, long term care management, addiction services, public health and home care staff) were relatively neutral about the concept of regionalization, but much more critical about its implementation.

## **Limitations of the Regional Concept**

Some stakeholders, notably health care providers, question the value of Regional Boards, and some concern is expressed across the province about regions being too large to properly address local needs.

During the course of this study, a number of issues were brought to light concerning the conceptual framework of regionalization. Some providers, especially physicians, maintained regionalization's structure adds a layer of bureaucracy to the current structure, making it harder to provide the care Nova Scotians need, and adding to, rather than decreasing, administrative costs. In part this may be a reaction to implementation issues, but it also suggests a rather basic difficulty with the structure accompanying regionalization. These stakeholders do not see the value of Regional Boards, and they do not seem to believe the regional process is fundamentally different (certainly not better) than what would be possible directly through the Department of Health.

Many stakeholder groups expressed concerns about the size of the health regions being too large, making it difficult to accurately assess and deliver the specific health care each area needs. Furthermore, the regions' large size is perceived to put more strain on already taxed personnel—more travelling means less hands-on time at facilities, contributing to some stakeholders' perception that direction is lacking. One obvious solution may be to increase the number of regions. But, at some point, having more regions begins to resemble the previous system, along with its inherent weaknesses.

Physicians did not support another fundamental aspect of regionalization's concept. This group claimed that moving the community focus of health care from the hospital board (and its physical attachment to the hospital) to a CHB was apt to "disenfranchise" community members. As such, it would reduce Nova Scotians' participation in their health care planning rather than encourage it. Paradoxically, this group appears to be saying that one of the key structures intended to strengthen citizen involvement (the CHB) has actually weakened it.

In general, the research shows that stakeholder groups whose responsibility it is to implement and administer the health care system (i.e. Board members and facility CEOs) are more positive about the concept of regionalization than those who must deliver health care services under this new structure.

## **The Public's Perspective**

Nova Scotians know very little about regionalization, but readily hold it responsible for the negative changes they see happening to health care in the province today.

The general public's experience with regionalization represents a wholly different perspective in comparison with those stakeholders more directly involved in managing the health care system or providing services. Nova Scotians, as citizens and health care consumers, are not well informed about the regionalized health care system, in terms of its purpose, structure or how it is being implemented. For this population, regionalization serves as a ready lightning rod for public anxiety about the future of health care. With the public's confidence in the health care system eroding and growing concern about the future, Nova Scotians have little basis for concluding that this reform has done anything but make the problems worse, if not cause some of them in the first place. Most people assume that regionalization has been implemented to cut costs and streamline operations rather than improve services, and some associate this type of change with amalgamation, which does not currently enjoy a positive image, given the controversies that have surrounded reforms in school boards and municipal government.

These concerns notwithstanding, Nova Scotians' actual experience in using the health care system is generally positive, in terms of the quality of care they receive from health care professionals, hospitals and non-acute services such as home care. What is beginning to worry consumers is access to the services they need, in terms of longer waiting times for services and having to travel farther than before to get services that were previously available locally. Regionalization serves as a ready scapegoat for this disturbing trend. They are ready to blame regionalization for the shortage of nursing staff, for longer waits or other experiences that might be related to cost cutting. Although the public has opinions about health care and are quite ready to extend them to regionalization, to answer the question of whether they agree or disagree with the concept would be somewhat misleading since their awareness and knowledge is so low.

## **Implementation Is the Basis For Stakeholders' Opinions**

Stakeholders' perceptions and conclusions about the value of regionalized health care are based primarily on their experience with its implementation.

Whether or not stakeholders agree with the *concept* of regionalization, stakeholders' opinions about its implementation is the primary basis upon which they are deciding whether they believe it is a good thing and will work to support it. The qualitative research reveals that many individuals admit to not being able to distinguish between the effects of regionalization versus those resulting from other systemic changes. Nevertheless, the current state of the health care system is attributed to regionalization.

Only under direct questioning (in qualitative research) did some providers acknowledge they could not tease apart regionalization from other changes. This is somewhat similar to consumers' reactions; the very fact a different structure has been implemented is enough to make it the focal point of stakeholders' annoyance.

Notwithstanding the natural reaction to focus discontent on change, stakeholders' opinions are driven by their *experience* with the health care system since regionalization, not the *concept* of regionalization. And for many providers and front-line staff, the experience has been primarily negative, both in terms of how their working lives have changed, and also in terms of their evaluation of whether patients are getting better or worse care. At the moment, it seems that implementation of regionalization has been handled in such a way, and at such a time, as to prompt mostly negative associations. These associations stand out in stakeholders' minds when they review regionalization's successes to date.

## Progress in Achieving the Goals of Regionalization

As with their opinions about the concept of regionalization, stakeholders' opinions as to whether regionalization is achieving its intended goals are varied. However, it is safe to say that regionalization is much more likely to be seen to be achieving process-related goals (promoting cooperation instead of competition, increasing citizen involvement, tailoring programs to meet local needs, and re-directing funding to patient care) than outcome-related goals (increasing quality of care, increasing patient access to care, and emphasizing primary care).

That regionalization is not seen to be meeting patient outcome-related goals should not be regarded as failure. First, given the relative newness of regionalization, it should be expected that stakeholders do not see a progression toward outcome-related goals. Many stakeholders remarked it would be difficult for them to evaluate regionalization properly because not enough time had passed for: a) the structure to be fully implemented; b) for the 'kinks' to be worked out; and c) for its effects to be known. This does not mean stakeholders are not disenchanted that regionalization has not resulted in more progress toward outcome-related goals in particular. But they do acknowledge a need to evaluate regionalization in the context of what is a realistic measure of success *at this time*, not just whether regionalization is currently successful.

Second, there are inherent difficulties in trying to evaluate regionalization for the simple fact that other fundamental changes have affected the health care system in Nova Scotia, not the least of which has been budget reductions. Many stakeholders, consumers among them, strongly maintain that lack of financial resources have undermined the implementation of regionalization. To paraphrase one Sydney consumer, "if the money doesn't exist, it doesn't matter how good the *idea* is." These two points help set a context for interpreting stakeholders' conclusions about how successful regionalization has been to date.

As with their reactions to the concept of regionalization, stakeholder groups offer a continuum of views about the degree to which progress has been made toward regionalization's goals. And as with their views on the idea of having a regionalized system, the more favourable views are held by those groups not directly providing care. The RHBs, NDOs, CHBs (and to some degree site managers), are notably more positive about the degree of success, even noting some improvements in outcome-related goals.

Physicians, home care, addiction services and public health staff are not as optimistic about the degree of progress in achieving goals, not even process-related goals (although on specific goals, some groups admit there has been progress). Indeed, although public health and addiction services workers note some positive changes to process-related goals, they observe regionalization overall has *decreased* the emphasis placed on these sectors of health care.

Nurses and front line staff are somewhat more positive than other providers about whether regionalization is achieving process-related goals, but they do not see much in the way of improved quality of health care services provided to patients.

## Process Goals

**Stakeholders are most likely to see progress in promoting cooperation and increasing citizen involvement. Some improvement has been noted in tailoring programs to meet local needs, but few see any evidence of funds being re-directed to patient care.**

Many stakeholder groups acknowledge progress has been made in process-related goals of regionalization, which include the structures and processes necessary to accomplishing outcome-related goals. But even opinions on the degree to which process-related goals have been accomplished is mixed. For example, Board members and site managers are more likely to acknowledge progress than provider groups, even though these latter groups do note some improvement. Provider groups have simply not noted improvements to process to the same degree as Board members and site managers. As would be expected, consumers are very unlikely to note any process-related activities.

Most stakeholder groups appear to see some progress being made toward promoting cooperation and increasing citizen involvement. Board members, site managers, nurses, addiction services and public health providers, front-line acute care staff; and home care workers have all noted more cooperation between and among people in the health care sector.

If other stakeholder groups are like nurses, they may be experiencing more cooperation between different geographical locations and also between different sectors of the health industry. This change was seen to result in more information sharing about processes and procedures, more integration between sectors which ultimately should lead to more focus on patient outcomes.

CHBs in particular see improvements in the area of increasing citizen involvement. This might be expected since they are somewhat responsible for this function. However, other stakeholder groups also support this finding (with the notable exception of physicians).

Some stakeholder groups are not overly positive about regionalization's progress, even in achieving process-related goals. For example, home care workers and long term care management, while offering a variety of views about regionalization, do not appear to see much progress in moving forward. They do acknowledge that regionalization is achieving its goals in terms of promoting cooperation and increasing citizen involvement.

Physicians stand apart from all other stakeholders in that they do not see any improvements in increasing citizen involvement or in improving cooperation. Because of consumers' low awareness of CHBs, it is likely that they would agree with physicians' assessment of minimal citizen involvement, but this is based more on lack of understanding than clearly-defined opinions about what has been happening in the system.

RHB/NDO Board members, and site managers are relatively positive about progress made in tailoring programs to local needs. Interestingly, CHB members do not share this outlook, perhaps because there may be differences between what they advise and what they see actually happening. Or they may feel their recommendations simply have not had time to be incorporated into strategic plans for the region. Home care and front-line staff see at least a little progress being made in tailoring programs, while other stakeholders perceive little, if any, improvements in delivering more tailored programs to local communities.

Only the RHB and NDO Board members reported regionalization has resulted in being able to re-direct funds to patient care. Other stakeholder groups were more likely to report that regionalization has either not facilitated directing it to patient care, or has not saved any money to re-direct.

## **Patient Outcome Goals**

**Board members can see progress in achieving outcome-based goals of regionalization, but most provider groups see either no change or a decline in the quality of care provided to Nova Scotians.**

As mentioned above, few stakeholder groups note progress in goals related to patient outcomes, specifically improving patient care, improving patient access to care, or in emphasizing primary care and shifting the focus to other channels, such as home care. Board members, and site managers believe progress has been made in reaching patient-outcome goals. Out of all the stakeholder groups, CHB members are the most positive with regard to regionalization's effect on outcome-related goals. Among this group, members in the Central and Eastern region are the most positive about the degree of progress over the past three years.

Many of the other stakeholders are ready to conclude that since regionalization: a) it has been harder for providers to deliver on these objectives; and b) there has been a general decline in the level of quality and access to care, and the emphasis placed on primary care. For example, a sizeable minority of nurses, addiction services and public health workers see less emphasis now being given to primary care. Many providers note longer waiting lines, bed shortages and longer travel times for consumers. They find their own workloads have increased, and their ability to provide the quality of care they want has been compromised,

either because of reduced resources or increased responsibilities (or both). All in all, if regionalization is to be judged solely on providers' opinions about patient-outcome goals at this point in time, regionalization would be seen to have failed.

## Structure and Implementation Issues

Beyond regionalization as a concept, stakeholders also raise, or have a perspective to share on, a number of key issues pertaining to the structure and implementation of regionalized health care. In some cases these issues represent problems or barriers that are seen as standing in the way of achieving the established goals for this new system.

### Lack of Funding or Resources

**Inadequate funding is seen to pose a major obstacle to making regionalization work, and front-line providers are struggling with staff shortages that are causing workload stress and affecting patient care.**

Most of the stakeholder groups included in this research raised concerns about funding or resources at some level. Those responsible for governing and managing the system (Regional Health/NDO Boards, site managers) emphasized a lack of funding as the number one barrier standing in the way of successful implementation of the regionalized system. Funding and budgetary problems also emerged as the number one source of personal frustration among RHB/NDO members, most notably those with the QEII and IWK/Grace. This is not as likely to be an issue for CHB members, which is not surprising since these local boards do not have the same level of governance or management responsibilities.

For health care providers, the issue is not so much funding for the system but the problems that regionalization has created in terms of reducing staff resources and/or increasing workloads. Nurses and other front-line workers see regionalization as having been responsible for creating additional work-related stress on themselves and other workers. All provider groups (including those in non-acute areas) also believe that regionalization has had a negative effect on patient care through reduced access to services, longer waiting times, longer travel distances and a shortage of beds. Physicians in particular are especially negative in concluding that the regionalized system has been responsible for creating or exacerbating problems with the quality of care available to Nova Scotians.

## Communications

**Stakeholders emphasize the need for more communications throughout the system, but this need is not well defined, and may also reflect other problems related to implementation.**

Most provider groups stressed the need for better communications. However, it is not entirely clear what is meant by “communication”. In most of the qualitative research (except with consumers), participants exhorted the need for more or better communication, or derided the current level of communications. When asked what specific communications they referred to, conversations would often focus on “no one really knowing what was going on,” or a claim that “they don’t tell you anything.”

Considered along with the results from the quantitative research, it can be concluded that the cry for more communications may be a symptom of other issues. At the same time, it may be that implementing more communications activities would relieve some issues among provider stakeholders in particular.

Providers especially, but also consumers, have been undergoing enormous amounts of change during the last few years as Nova Scotia’s health system evolves. And change creates a need for more communications than under normal circumstances. As noted throughout this report, stakeholders are calling for more clarification of roles, more leadership from the Department of Health, more ability to give input, and better identification of responsibilities and authority. These are all areas in which communications can play a critical role. With regard to role clarification, for example, is the problem that roles are not defined? Or is it that the definition and scope of these roles have not been communicated clearly? If it is both (which seems likely), then at the very least, maintaining a flow of communications would surely help the situation.

The tenor of stakeholders’ discussions around regionalization’s successes was notably cynical. They have heard little to counteract their own negative experiences with implementation, and much that emphasizes regionalization’s “failures.” In the absence of information to the contrary, they are left with their own (and their colleagues’) primarily pessimistic outlook about what regionalization means for them and their work. Communications has a large role to play in creating a positive environment, one which will encourage people to work toward something and work together.

At the heart of the matter may be providers’ need to feel they are part of the change, rather than feeling that change is being “done to them.” Indeed, the very act of putting effort into ensuring that stakeholders are well-informed (especially with regard to the progress being made) tells stakeholders they are critical and important to the process. Finding appropriate and credible channels of communications may be a difficult task, but given stakeholders’

obvious distress over regionalization and their clearly articulated need to feel they know what is going on, improving communications will be necessary if further progress is to be made in fulfilling the goals of this reform.

## Clarification of Roles and Responsibilities

**There is limited understanding or agreement about which level of the system should have the primary role for many areas of health care planning and delivery.**

A major issue for many of the stakeholders interviewed is a lack of clarity and/or differences in opinion around which part of the health care system is responsible (and accountable) for the planning and delivery of health care services. At one level this is not surprising given that it is a relatively new reform, but at another level it is notable how little consensus there appears to be in this area.

With the exception of a few areas (e.g. province taking the lead on Pharmacare and setting province-wide standards; CHBs leading on primary care), there is little consensus either within or between stakeholder groups as to which level of the system should have primary responsibility for specific areas of health care planning, management or delivery. This partly reflects a limited understanding by some of what these areas involve and how they are currently provided. But it also points to a problem of both communication (educating stakeholders about the system) and also gaining acceptance of the new structure in terms of how best to plan and delivery different areas of the system.

Apart from this general pattern, there are some distinct perspectives evident in how different stakeholder groups believe health care responsibilities should be apportioned across the system. RHB/NDO Board members stand out as placing a particularly strong emphasis on the province assuming the lead role for most areas of health care. Among this group, the only areas on which there is strong agreement for a lead role at their own level is in regional planning of services, managing hospitals and planning primary care. The fact that RHB/NDOs place more emphasis on provincial than regional responsibility could possibly reflect the desire for stronger leadership from the province than they have seen to date. It is with the *delivery* of health care services that these Boards are most apt to see themselves as taking the lead role, although NDO members are more likely than RHB members to look to the province in these areas, likely reflecting some concerns about the capabilities of Regional Boards or a loss of control over their own decision-making.

Physicians are also a group that looks mostly to the province to take the lead in many areas of health care planning. In this case this perspective is driven primarily by animosity towards the regional structure, and the fact that many physicians question the need for Regional Boards in the first place. This group is more likely than not to feel that hospitals should be

operated by CHBs rather than RHBs.

Community Health Board members express a very different view about responsibilities for health care planning, one that is much more decentralized, in comparison with most other stakeholders. This perspective reflects two factors. First, CHB members view regionalization as a decentralized approach to health care, and so they are keen to develop their role at the local level in many areas, such as primary care planning and public education. Beyond this, they look to the Regional Boards to take on much of the responsibilities that they cannot themselves assume. Second, CHBs have not yet established a constructive relationship with the Department of Health, so that Board members may lack an understanding of the province's or the Department's role.

This decentralized focus is noticeably less evident in terms of responsibility for health care delivery, where CHB members tend to look to the regional level.

Finally, home care workers and long term care management are more likely than not to feel their areas should remain under provincial jurisdiction, rather than being transferred to the Regional Boards. This view is neither universal nor consistent across regions. It is in the Central region, for instance, where home care workers are among the strongest proponents for remaining a provincially-directed service, while long term care operators are most apt to see merit in becoming part of the regional structure.

## **Department of Health Role**

### **Many stakeholders do not clearly understand the province's role in the new regionalized health care system.**

One issue to emerge through the research is the role and function of the Department of Health, which is the lead government agency overseeing health care at the provincial level. Because regionalization is seen as a decentralization of the health care system, it has created some uncertainty over what role the province will continue to play. With the provincial role not well understood, some of the problems and delays encountered in implementation are being attributed to some degree to a lack of leadership at the top.

RHB and NDO Board members have the closest ongoing link with the Department and this is reflected in the fact that their view of the Department's role is largely consistent with its actual mandate under the regionalized system. These Boards are generally positive about their ongoing working relationship with the DOH, though this is more likely to be the case with NDOs than with RHBs (with the Central and Western Region Boards the least positive). While this collaboration does not appear to be a problem area, many members do see the need for more provincial leadership and better communications.

As noted above, CHBs do not currently have as much connection with the DOH, and so they have less appreciation of the provincial role. Their dissatisfaction with the Department likely comes out of frustration with their Boards not being given a clear mandate and resources to assume the role they hope to be leading health care at the local level.

## **Role of Non-Designated Organizations**

**The province's four Non-designated facilities are widely seen to play an important province-wide role. Stakeholders believe they should be more closely integrated into the regional system, but not formally designated under Regional Boards.**

One of the key issues being addressed by the Task Force is what the most appropriate role should be for the four Non-designated Organizations in the regional system. There is widespread recognition and agreement that these four facilities are distinct from others in terms of playing an important province-wide role with respect to the health care services they provide. This is much more the case with the QEII and IWK/Grace, however, while the Cape Breton Healthcare Complex and (to a lesser extent) the Nova Scotia Hospital are more apt to be seen as serving the regions in which they are located.

More at issue is whether or not these facilities should be formally designated under the wing of Regional Health Boards.. On this issue there is no consensus, but on balance the weight of opinion appears to be in favour of further integrating the NDOs into the health system but not going as far as fully designating them under RHBs.

Not surprisingly, the perspectives of RHB and NDO Board members are somewhat different on this matter. RHBs are among the strongest proponents of designating NDOs although no more than half favour this approach for any of the four facilities (with the QEII and CHBC the two most popular candidates). Members favour such designation because they see merit in having all facilities within one integrated system, and for purposes of planning, budgeting and service delivery.

NDOs are mostly opposed to being designated under Regional Boards, with only five of the 32 members interviewed seeing this as the right approach for their own Board. Designation is not supported because of the provincial role which these facilities play, but also in some cases due to a lack of confidence in RHBs, as well as resistance to ceding autonomy they currently enjoy.

Other stakeholder groups express only limited support for the designation of NDOs, again seeing the value of greater integration but questioning how this would work given the province-wide role these facilities are serving. Stakeholders are most likely to see value in integrating or designating the CBHC under the Eastern RHB given the regional focus of the

former. There may be strong potential for greater integration in this case because these two Boards currently enjoy the most positive working relationship of any two health boards in the province.

## **Role of Community Health Boards**

**The importance of Community Health Boards in providing a community focus on health care is strongly endorsed across the province, but there remains some uncertainty about how this role fits within the overall system.**

Also addressed in the research is the role that Community Health Boards play in the regionalized health care system. Few stakeholders question the need for a local level in this type of system. There is a general, if not complete, understanding of the distinct role that CHBs play, in terms of identifying community needs and priorities, providing a forum for public input and advising Regional Boards, and in taking the lead in community-based health planning—areas in which RHBs cannot adequately handle.

Moreover, this role is largely endorsed, with most stakeholders acknowledging the need for CHBs as well as RHBs in the province's regionalized system. Yet the strength of agreement on this point varies somewhat across stakeholders and also across regions, although the pattern is not a consistent one. The need for CHBs is most widespread among Northern and Eastern Regional Board members, among addiction/public health workers and home care workers in the Northern region, while least evident among long term care management and nurses in the Central region. Even among CHB members themselves, there is a notable absence of consensus on the need for both CHBs and RHBs, with those in the Northern region least apt to be convinced of this.

While the importance of CHBs is well established, some concerns are expressed with how well their role within the regional system has been defined.

While RHBs are positive about their ongoing collaboration with their CHBs, the CHBs are not quite as positive (particularly in the Northern region), in part because they are not satisfied with the degree of community input into RHB decisions, and their level of interaction with these Boards. There is a clear need identified (and also endorsed by RHBs) to have greater representation of CHB members on Regional Boards to ensure better incorporation of community priorities.

As well, Community Health Boards do not yet have much of any public profile in most areas of the province (and particularly in the Central Region). Nova Scotians do not feel there is sufficient community input into local health decisions and/or services, because they do not see any evidence of community involvement, and this is becoming more of a concern with the shifting focus towards regional decision-making and the closure of some local hospitals. Once CHBs are fully functional they could be the key to building stronger public confidence

in the health care system.

## **Regional Decision-Making**

**Regional and NDO Board members are generally satisfied with the decision-making at the Board level in terms of both process and outcomes, but this view is not shared to the same extent by other stakeholders.**

RHBs and NDOs are largely positive about the way they are operating, both in terms of how they are functioning and in the decisions being made. This evaluation stems from important process supports, such as receiving good information to support decision-making (e.g. utilization data, physician vacancies), a written business plan, the right composition of Board members, and good internal communications. With the notable exception of the CBHC, NDO Board members are not as likely to be quite as positive, particularly those serving with the Nova Scotia Hospital and (to a lesser extent) the IWK/Grace.

Other stakeholders are not as inclined to share this positive assessment of regional decision-making. Acute care facility site managers are generally satisfied with regional decision-making, but quite the opposite view is held by physicians. For all of these groups, a major problem is the degree to which they have adequate input into the process.

## **Stakeholder Input**

**Stakeholders' greatest problem with the regionalized health care system is the absence of adequate input into decision-making at the regional level.**

Perhaps the single biggest problem stakeholders have with the regionalized health care system is the extent to which RHBs are receiving and using input from other key stakeholders across the province.

Those serving on Regional Health Boards tend to feel they are receiving an adequate level of input from health care providers and local facilities (and perhaps they would have concerns about more extensive input creating problems with their decision-making).

NDO Board members share this view with respect to the adequacy of representation from health care providers, but feel that local hospitals (with whom they share a common perspective) do not have sufficient input into RHB decisions. Site managers of local facilities see Regional Boards as the right level of the system to take the lead role for many key areas of health care, but at the same time this shift in decision-making has left many feeling they now lack the ability to make the kinds of decisions they need to make to adequately manage their facilities (this view is most pronounced among managers in the Western and Northern Regions).

Other stakeholders also express the view that the current regional structure and process

does not provide adequate opportunities for input from health care providers or local facilities, which would appear to run counter to the very purpose of decentralizing health care in the first place. This view is not limited to stakeholders' own particular group: Providers are just as likely to feel local facilities lack the necessary input, as site managers are to believe that providers are being left out of the process.

## **Board Composition**

### **Concerns about insufficient input into regional decision-making leads to an expressed need for stronger stakeholder representation on Regional and NDO Boards.**

With concerns about having adequate input into RHB decision-making, it is to be expected that many stakeholders feel that part of the problem is the composition of these Boards. RHB members themselves are largely satisfied that the current composition of the Regional Boards is appropriate in terms of the requisite expertise and stakeholder representation. This is also the case for two of the NDOs (IWK/Grace, CBHC), but less so for the QEII and NSH, where some members express concerns about vacancies or the absence of representation from either health care providers or other interests (e.g. minorities).

But the perspective of other stakeholders is quite different. Health care providers (including physicians, nurses and other acute care front-line workers) express the view that their professions (collectively) should have much stronger representation on RHBs and NDOs, to comprise at least 25 percent of board membership, with many placing the desirable proportion at 50 percent or higher. Similarly, CHB members also see it as important that they be directly represented on Regional Health Boards in a significant way.

There is much cynicism expressed over how the CHBs are formed, particularly from the consumers stakeholder group, but also among physicians and nurses groups. That they are appointed, rather than elected, diminishes their credibility as a body that might actually make recommendations in the best interest of Nova Scotians and the health care system, even if politically unpopular. Some providers know Regional Board members were intended to be elected; that they are not makes them even more suspicious of the whole regional approach.

## Regional Boundaries

**The current health region boundaries are not identified to be a significant problem with the system, but there is concern that regions may be too large to adequately address local needs.**

Another issue being examined by the Task Force is the appropriateness of the geographical boundaries delineating the health regions. There is no consensus on this question, but the balance of opinion is clearly on the side of the current boundaries being appropriate for serving the needs of the population. The primary reason for questioning these boundaries pertains to concerns stakeholders have with these regions being too large to allow RHBs to properly identify and address the needs of local areas within each region – this view is articulated by at least some portion of each stakeholder group included in the research.

Opinions about the health region boundaries vary noticeably across stakeholder groups, as well as across the regions themselves. The current boundaries are most widely endorsed by RHB and CHB members, as well as by site managers, nurses and home care workers, and the general public, while no more than a third of physicians share this view (driven by this group's general opposition to the regional structure and questioning of the need for regions at all given the size of the province). And within each group, views differ across regions although not in a consistent pattern. For instance, endorsement of the Central Region boundaries is higher among CHB members but lower among RHBs and addiction/public health staff. The Western Region, however, stands out as one in which stakeholders from different groups are most likely to raise concerns about the geographical area being too large.

## Consistency Across Regions

**Opinions are divided on whether or not there needs to be a consistent standard for health care management structures and procedures common to all four regions.**

One of the implications of a regionalized approach to health care is the increased flexibility for regions to adopt different approaches in how they manage and deliver services. To what degree should regions tailor the system versus adopting a consistent approach? Opinions on this issue are mixed, with no particular stakeholder group strongly in agreement on either side. CHB members are the strongest proponents of having a consistent standard for both management structures and practices, while this view is shared by RHB members in the Central and Western Regions, but opposed by those in the Northern Region. Site managers and physicians are divided on the merits of consistent standards.

The hesitation about consistent management structures and practices comes about in part out of the belief that the value of a decentralized approach is grounded in the flexibility in tailoring to specific regional or local needs. But it may also reflect a concern that

establishing consistent province-wide standards may further erode the ability to have influence on regional decision-making.

Although there is no consensus about the need for consistent standards in the management of health care, the Nova Scotians place great importance on the system providing the same level of **patient care** in all regions. This priority is of particular importance to residents of the Northern and Eastern regions, who may be concerned about not having access to the same level of care that is provided in Metro Halifax.

## Future Direction

### Key Priorities to be Addressed

**Stakeholders identify as top priorities the need for more funding, improving communications, clarifying responsibilities and boosting stakeholder input at the regional level.**

This research has documented a range of perceptions and experiences across the province in terms of how regionalization has and has not progressed over the past three years. It has also probed views on how the system should proceed from this point forward, specifically in terms of what key things need to be done that will make the most difference in making regionalization a success in terms of achieving its goals.

Overall, despite the problems and challenges that have accompanied this reform of the province's health care system, most stakeholders fundamentally accept, if not support, the regional approach to health care in Nova Scotia. Most can identify on how to make this system work, or work better, rather than questioning whether or not it is the right approach (physicians being the notable exception).

Stakeholders appear to agree on the top priority areas to address to make regionalization more effective, with some variation that reflects the particular experiences or issues that specific stakeholders have had with the system. Most stakeholder groups advocate the need for increased funding to provide the resources necessary to make the system work as it should, with this recommendation given particular emphasis by RHB and NDO members. Nurses put their own twist on this issue with their focus on addressing the staffing shortage and workload problems experienced by their profession and others on the front line.

Beyond the identification of new resources to support the system, much of what stakeholders recommend focuses on addressing process issues, such as improving

communications across the system, clarifying responsibilities, boosting stakeholder input into regional decision-making and providing more education.

## **Task Force Expectations**

**Many stakeholders are hopeful, if not optimistic, that the Task Force review will make a constructive difference in addressing the issues currently facing regionalized health care in Nova Scotia.**

As part of the research, stakeholders were asked about what expectations, if any, they have about the outcome of the Task Force review of regionalization. As with most other issues covered in this research, a range of views are expressed, encompassing both positive and negative expectations. On balance, however, stakeholders are more likely to be either positive or at least hopeful (i.e. that something constructive will result from the process), than cynical and negative (being nothing more than a waste of time and money).

Many stakeholders express keen interest in what the Task Force concludes, and will be watching closely to see what impact it ultimately has on how health care is managed and delivered in Nova Scotia over the next few years.

## **List of Research Reports**

1. Regional Health and NDO Boards
2. Community Health Boards
3. Acute Care Facility Site Managers
4. Registered Nurses
5. Physicians
6. Acute Care Front-line Staff
7. Home Care Staff
8. Long Term Care Management
9. Addiction Services/Public Health Staff
10. Consumers and General Public

## Appendix 2

### Submissions Received by the Minister's Task Force on Regionalized Health Care in Nova Scotia

Submittor	Organization/Region	Recommendations/Comments
Bonnie Allan	CHB member, Northern Region	Elect CHB members and have them form the RHBs to be more accountable to the communities.
Dr. Minoli Amit	Physician, Eastern Region	Need more funding to RHBs. Continuity of care should proceed from the local institution.
Rebecca Attenborough	Reproductive Care Program of N S	Need more autonomy at the local level. Address the problem of centralization & specialization in maternity care
Trudy Bengivenni	Chair CHB, Western Region	Legitimize CHBs. Use N.S. Health Goals in assessment process. Need for partnering at all levels.
Joanne Bertrand	Schizophrenia Society of N.S.	Need for collaboration between Minister and Non Government Organizations (NGOs), i.e. Have NGO advisory body. Better mechanisms for funding NGOs are needed.
Arthur Blades	Chair CHB, Western Region	Have 2/3 RHB members nominated by CHBs as planned and legislate CHBs.
Dr. Brodarec	Physician, Western Region	Need physician say in health decisions and election of RHB members. Reduce bureaucracy. Need more local input. Auditor Gen. should audit RHBs. Make Social Services, Veteran's Affairs & Home Care Program pay for patients who have extended stay in the hospital because of lack of long term care beds elsewhere. RHBs could be eliminated.
Barbara Campbell	Multicultural Association of NS	Include ethnic representation in health care policy making and evaluation. Support community based research & develop models to improve and set standards for cross-cultural health care. Regionalization must reflect the growth of cultural & ethnic diversification in their districts.
Can. Mental Health	Central Region	Legitimize CHBs. Identify core services and their standards & share them with the public. DoH & Community Services must work together. Status of NDOs must end in the Central Region. NGOs need a clear definition of their fit in the system. There is an urgent need to expand services of the Mobile Crisis Intervention Program in the Central Region. Continue the process of regionalization.

Submittor	Organization/Region	Recommendations/Comments
Roger Cann	Representing 11 CHBs Western Region	Continue with process of regionalization. Legitimize CHBs. Have representatives of CHBs make up 1/3 of RHBs. Modify the size of regions. A broadening of local perspectives has resulted from regionalization.
Roger Cann & Delmar Jordan & Rodger Forsman	Chair, vice-chair, & former chair Western Region	Need for adequate funding to RHBs. RHBS are necessary to provide coordination and support CHB.
Chebucto West CHB	Central Region	Commit to "Blueprint" .Legislate CHBs. Designate all hospitals. Revisit CHB boundaries. Need mechanism for formal evaluation of regionalization. Role of PHC should reflect RHB & CHB existence. Gov't should provide adequate funding. Credit volunteers who were involved in regionalization.
Robert Cook	NSAHO	Legislate CHBs. Clarify role of RHBs. DoH role should be to do strategic planning, policy development, standard setting and evaluation, oversee insured services, and funding. Clarify role of PHC. Develop system-wide communication strategy. Implement a needs adjusted, population based funding model. Health providers & DoH together develop an accountability framework. Develop an information system to allow DoH & regions to develop performance standards & measure outcomes. Continue work on alternative funding to physicians. RHBs and NDOs are in urgent need of capital funding. Integrate NDOs into the system. Devolve Home Care to the regions. Tertiary & other provinciaprograms should be a shared responsibility of DoH, RHBs, and care providers. Implement a system wide human resource planning process. Establish a Single Entry model.
Siobhan Doyle& Phyllis Sweet	Adolescent Health and Support Centre, Western Region	Asking for help and commitment in providing the youth with education, information, clinical services and counseling in the areas of sexual & emotional health.
Robert Crane& Charles Sampson	Citizens, Eastern Region	Revenue Canada should allow more than 17% for medical expenses. It would be fair if we could use the same mileage rates as government employees use when having to access medical services away.
Carl Crouse	Citizen, Western Region	RHBs should allocate their budgets to meet regional needs.
Rev.Canon SJP Davies	Chair CHB, Western Region	It's time for CHBs to become legal entities and for Gov't to give them full support.
Christine Dishlin	Pharmacist, Central Region	Managers should be team players. New staff should be properly trained. Develop a standard formulary for the province.

<b>Submittor</b>	<b>Organization/Region</b>	<b>Recommendations/Comments</b>
Dr. William Enright & Physicians, Central Region Dr. Mark Kazimirski		RHBs should be advisory bodies only and have elected members. Consider elected hospital boards. RHBs should have Chair of Med. Advisory Committees, Pres. of Medical Staff, & Senior Director of Medical Services on the RHBs. CHB members could be on RHBs and hospital boards. Elect CHB members. Regionalization admin. costs should be audited by Auditor General & made public. Dartmouth Gen. should be a regional hospital. QEII should be a tertiary centre only.
Donald Ferguson	Chair, Cape Breton HCC	Keep CBHCC as NDO but merge it with Eastern RHB, & create a separate region. Include Home Care and Long Term Care as a service of CBHCC.
Joan Fraser	Health Charities Network of N.S.	Health Charities should be key partners with DoH and RHBs in everything. Dr. Fred French Chair, Central RHB. All organizations need clearer role definition. Legislate CHBs. Commit to full regionalization-devolve Home Care, Continuing care and NDOs.
Dr. Aulayne Jeans & Dr. Magdy Fouad	Physicians, Northern Region	Make regions smaller. Promote integration. Bring accountability and authority back to communities.
Charles Jess	Citizen, Western Region	Accountability back to communities. Have boards and staff that are accessible.
Paul Girard	Citizen, Central Region	A case management model should be implemented in all regions to provide integrated patient care.
Mr. J.W. Gogan	Chair, Aberdeen Hospital Foundation	Clarify roles of boards. Have elected. Address the issue of accountability as soon as possible.
Dr. John Hamilton	Physician, Eastern Region	Define core services. Return to hospital boards. Expand Home Care and home hospital throughout the province. Integrate Information management.
Mary-Jane Hampton Richard MacLachlan Sandra MacLennan Brian Vandervaart	Citizens, Central Region	Have fewer CHBs who plan, fund & administer Primary care services. RHBs must have 2/3 reps from CHBs. Abandon fee-for-service for physicians and have bigger role for nurses in primary care. Implement regionalization completely.
Heather Henderson	Nova Scotia Nurse's Union	Embrace "Blueprint". Elect RHBs & CHBs.
Heather Henderson	Nova Scotia Fed. of Labour, CLC	Elect RHBs & CHBs. Legislate CHBs. Have worker reps on labor/management advisory committees.
David Hessie	Chair CHB, Western Region	Let CHBs evolve. Need more health care resources for seniors and youth. Establish autonomous healthcare districts for Yarmouth, Digby and Shelburne counties for local input to Western RHB.

<b>Submittor</b>	<b>Organization/Region</b>	<b>Recommendations/Comments</b>
John Higgins	CEO, Eastern RHB	Devolve Home Care & Long Term Care. Have a “single entry”. Legislate CHBs. Increase funding for Primary care projects. Need better information systems. Implement population needs based funding.
Debbie Kelly	Citizens to Save our Health Care	Clarify to the public the roles of RHBs, CHBs, & NDOs .Legislate CHBs. Establish Community Health Care Centres, Home Care & Long Term Care. RHB members should be chosen from CHBs. Have PHC review the state of regionalization. Establish office of healthcare ombudsman.
K.Kurtzrock/J. Mason	NS Society Occupational	TherapistsEmbrace “Blueprint”. Expand Home Care and Occu. Therapy as home services. Establish Regional Clinical Advisory Committees of the RHBs consisting of all health disciplines to provide input to RHBs.
Patrick Lee	IWK/Grace Hospital	Maritime community involvement is essential for the IWK/Grace. Identify core services and access standards at community, regional and provincial levels. Clarify roles of DoH, RHBs, & NDOs. Providers must be accountable. Accessible continuum of care is essential.
Herb Locke	Community Action Committee, Western Region	Revisit Bill 95 for public discussion. NeedWestern Region accountability in the system. Legislate CHBs. and have 2/3 RHB members from CHBs. Concern that Foundation money may be handed over to RHBs.
James Lockhart	Health Services Foundation of the South Shore, Western Region	Now that there are Regional Health Boards, the role of Foundation Boards has to be clarified.Elizabeth LoganCitizen, Western RegionBring together and organize health services in communities under Community Health Care Centres.
Dr. Peter Loveridge	Physician, Western Region	Address reasons for regionalization. Have independent management audits of RHBs. Reduce administration at RHB level. Give more autonomy to local institutions.
Victor Maddalena & David Logie	CEO & Chair, Western RHB	Legitimize CHBs and have RHBs made up of 2/3 CHB members. RHBs should get multi-year budget and separate capital funding. Devolve Home Care and Long Term Care.
Mary Martell	Maritime Centre of Excellence	Recognize new generation of “empowerment factors” for Women’s Healthwhich can create stress and poor health. DoH & RHBs should discuss gender equity analysis of public health policy, build community/researcher capacity in women’s health, research caregiver and home care issues.
Frank MacDonald	Chair CHB, Eastern Region	Revisit RHB structures. Need for reps from CHBs.

<b>Submittor</b>	<b>Organization/Region</b>	<b>Recommendations/Comments</b>
Byron McDonald	Member CHB, Western Region	Make CHBs legal entities. Include CHB Chairs on RHBs. Public should be better informed about health care issues.
Anne McGuire	CEO, N.S. Hospital	Establish a provincial mental health system and align addiction and mental health services. Adopt population adjusted funding strategy with clear delineation of the role of provincial/tertiary programs within the province. Use a balanced scorecard to profile & monitor indicators of strategic & operational results. Implement Provincial Programs Board as outlined in the "Blueprint".
James MacKinnon	Chair CHB, Central Region	CHBs and RHBs should be equal. Organizations of health services should be focused only on local communities.
Angus MacIntyre	Citizen, Eastern Region	Community input into health care decision making is essential. Stakeholders need training in strategic planning, team work, partnering and public participation.
Chris MacIsaac	Citizen, Eastern Region	Community input into health care decision making is essential. Listen to front line workers for sound professional advice.
Brian MacLeod	Joint Ministerial Committee on Continuing Care	WHO definition of health must be embraced. DoH and Community Services must work together. Need for education on holistic approach to health. Need for "single entry" system. Clarify role of DoH. Need for multi-year budget.
Gordon MacLeod	Citizen, Eastern Region	Hospital staff need IDs on them. Standards for service should be developed. Tax payers should receive a report card on how the system is performing.
Marion MacLeod	Citizen, Eastern Region demoralization.	Have a massive training program to combat
Juanita MacPhee	Citizen, Eastern Region	Listen to front line workers for sound professional advice on determinants of health. Place emphasis on primary care, health promotion and prevention.
Shirley MacTavish	Citizen, Northern Region	Inform the public about the changes in health system. Increase patient education. Restructure CHBs or eliminate them. We need nurse-practitioners.
Laurence Mawhinney	Citizen, Western Region	Establish Community Health Care Centres. Eliminate RHBs and replace with Provincial Health Board. CHBs would then have an expanded role.

<b>Submittor</b>	<b>Organization/Region</b>	<b>Recommendations/Comments</b>
Donald Mercer	Citizen, Western Region	Inform the public about the changes in health system CHBs need staff and facilities to do good work of advising RHBs. Legitimize CHBs. RHBs should include CHB reps and have elected & appointed members. Place emphasis on primary care. Devolve Home Care.
Robert Mullan	Medical Society of N.S.	RHBs should include CHB reps and have elected & appointed members. Devolve Home Care and Long Term Care and integrate them with local hospitals. Restore community input. Physician resource plans must be a priority of DoH. Physician reps needed on RHBs. Physicians need input into their working conditions.
Dr. David Murphy	Chair, Heads Dept. Committee Dartmouth Gral, Central Region	Frustration from inability to communicate with decision makers. Chronic lack of funding. Total lack of confidence in CRHB. Experience with regionalization very poor. Would prefer to return to the previous system.
Frances Perrin	Chair, Central Region	Need approach to health that is promotion and prevention. Must include other gov't departments. Council of CHB Chairs could be a collaborative body working on health reform.
David Peters	NSGEU	Give a bigger role to CHBs. Eliminate NDOs. Inform the public about the changes in health system. Establish elected RHBs & CHBs. Fund and recognize NGOs.
Irving Pink	Citizen, Western Region	The public sees RHBs as part of the government. We should keep our hospital boards and have RHBs there only for assistance. We need to maintain the charity works and funding from these groups.
Dr. David Rippey	CEO, Northern RHB.	Legislate CHBs.and have CHB members on RHBs. Devolve H.C. and L.T.C. Clarify roles of DoH and RHBs. Funding to RHBs should be for 3 to 5 years. Do not abandon regionalization.
Dr. David Robertson	Physician, Western Region	The RHB should deal only with regional matters. Regional hospitals should be centres for each sub-region, each having an autonomous CEO and director of nursing. Staff morale would improve and they would have a facility that they can identify with.
Kristin Schmitz	Continuing Care Providers, Central Region	RHBs should plan for the region, develop policy and fund for continuing care only and governance, management & implementation should be done by institutions. Have a "single entry" model. Re-examine size of regions.

<b>Submittor</b>	<b>Organization/Region</b>	<b>Recommendations/Comments</b>
The Self Help Connection	Central Region	Self Help should be recognized as a health enhancing mechanism and funds should be allocated for it. Include NGOs as a partner in health care decisions. Complete regionalization process.
Elizabeth Semple	Chair CHB, Northern Region	Is it necessary to have four RHBs? No need for expensively made documents, etc. Reduce bureaucracy. Why don't RHBs have CHB reps? Public sees RHBs as rubber stamping bodies. Governments need to get at the root of social problems in order to fix health problems.
Shelburne & Area Chamber of Commerce Care	Western Region	Adopt WHO definition of primary health care. Acute Care hospitals are essential to attract tourists to an area. Shelburne should regain its day surgery. Restore community ownership and decision making.
Douglas Smith	Member CHB, Central Region	Listen to front line workers. Reduce bureaucracy & have only one RHB in the province. Have CHBs deliver services. Promote health promotion & prevention.
Robert Smith	CEO, QE II Hospital	A rational funding formula is essential. Enhance H.C. Integrate Continuing Care fully, have a "single entry" system & include QE II in its development. Establish provincial standards & a report card. Mandate a provincial info system. Identify core services. Clarify roles of the stakeholders. Let regionalized structures evolve. Include other Atlantic provinces in problem solving with us.
Howard Spear	Citizen, Northern Region	Inform the public. CHB status is confusing. Teamwork is needed.
Dr. Jan Sundin	Physician, Western Region	Should have one regional hosp. per region and use existing management. The previous program management system should be re-introduced as the current model is inefficient.
Brenda & Mark Taylor Western Region	Holistic Nutritionists,	Formalize CHBs. RHBS should address broad determinants of health. Fund and allow consumer choice of therapies.
Sr. Yvonne Vigneault	Hospital Admin., Eastern Region	Preserve geographic boundaries that have shaped the culture of St. Martha's Hospital & keep it as a secondary care facility. Concerned about the non-designation of the four facilities.
Anthony Weagle	Citizen, Western Region	Mental Health services need improvement. Need better management of our limited resources.
Cecilia Webb	President, RNANS	Revisit "Blueprint". Clarify objectives of regionalization. Ensure adequate resources are available for consistent delivery of services throughout the province. Address regional disparity of resources and support for professional development of nurses

<b>Submittor</b>	<b>Organization/Region</b>	<b>Recommendations/Comments</b>
Swarna Weerasinghe	N.S. Council on Multicultural Health	Have NSCMH rep. on RHBs. DoH, RHBs, & CHBs should give an annual report on how they address health needs of immigrants, Blacks, & First Nations. Form a Multicultural Health Secretariat funded by DoH to act in advisory capacity.
Norman Whynot	Citizen, Western Region	Reduce bureaucracy at DoH. Involve NGOs, as partners in health care decisions. Modify provincial funding.
Ken Wilkinson	Chair CHB, Western Region	Implement "Blueprint". Legitimize CHBs. Mandate RHBs to act as supervisor, ensuring provincial standards are maintained. Return governance to local hospitals.
Lynn Woolnough	Chair CHB, Western Region	Why don't CHBs have more power? Include physicians in health planning. Too much travel time in some regions. There is inconsistent funding among regions for similar projects. We need a seamless health care system. Home Care and VON should be under the RHB. We need to inform the public better.
Debbie L. Kelly	The Nova Scotia Citizen's Health to Care Network	Need for clear achievable goals and clear plan achieve the. Advocate for community health centres.

**Appendix 3**  
**“In Camera” sessions**

The Task Force proposes that “In-Camera” sessions should only be held when considering the following matters:

1. the security of the property of the boards
2. the disclosure of intimate, medical, personal or financial information in respect of a member, an employee or prospective employee or patient
3. the acquisition or disposal of property
4. decision with respect to personnel and/or collective bargaining matters
5. litigation affecting the board.



## Appendix 4

### Regionalization Structures and Their Responsibilities in Health Systems Across Canada April 1999

Province	British Columbia	Alberta.	Saskatchewan	Manitoba.	Ontario
Ministries	Ministry of Health / Ministry Responsible for Seniors	Alberta Health	Saskatchewan Health	Manitoba Health	Ontario Min. of Health
Regionalized Bodies	<p><u>Regional Health Boards</u> 11 -responsible for hospitals, continuing care facilities, home support services in <i>urban</i> regions. Also integrated community-based health services. This includes Public Health, Comm.Home Care Nursing, Comm.Rehab., Case Mgt., Health Services for Community Living, &amp; Adult Mental Health.</p> <p><u>Community Health Councils</u> 34 -responsible for hospitals, continuing care facilities and home support services in the <i>rural</i> areas.</p> <p><u>Community Health Services</u> 7 <u>Societies</u> provide integrated community-based health services in <i>rural</i> areas.</p> <p>(Child &amp; Youth Mental Health were transferred to Min. for Children &amp; Families.)</p> <p><i>All are directly accountable to the Ministry.</i></p>	<p><u>Regional Health Authorities</u> 17 -govern all health care delivery except Cancer Care &amp; Mental Health in the regions.</p> <p><u>Community Health Councils</u> 67 -promote health and provide community input to RHAs.</p> <p><u>The Provincial Mental Health Advisory Board</u> -to provide mental health services throughout the province.</p> <p><u>The Alberta Cancer Board</u> - responsible for the delivery of all cancer related services.</p> <p><i>Excepting CHCs, all are directly accountable to the Ministry.</i></p> <p><i>CHCs are accountable to RHAs.</i></p>	<p><u>District Health Boards</u> 32</p> <p><u>Health Authority</u> 1 (in the North) -both plan, deliver, and evaluate all health services except physician services, pharmacare, and private health care facilities.</p> <p>There are <u>no Community Health Boards</u>.</p> <p>DHBs and HA are directly accountable to the Ministry.</p>	<p><u>Regional Health Authorities</u> 13 -responsible for the delivery of all health services except pharmacare and fee-for-service physician services.</p> <p><u>District Health Advisory Councils</u> 1-4/ region -provide community input</p> <p>A <u>Community Health Assessment Unit</u> was established by Mani. Health to assist RHAs in completing &amp; implementing their Community Health Assessments. They act as liaison &amp; support.</p> <p><i>RHAs are directly accountable to the Ministry.</i> <i>DHACs are accountable to the RHAs.</i></p>	<p><u>Regional Offices</u> 10 New Ministerial offices to plan, manage funding for hosp, mental health, some aspects of comm. Health &amp; LTC.</p> <p><u>District Health Councils</u> 16 act as advisory bodies to the Minister at the community level.</p> <p><u>Community Care Access Centres</u> 43 coordinate, but not deliver, long-term care services.</p> <p><u>Municipalities</u> -responsible for Public Health.</p> <p><u>Health Services Restructuring Commission</u> -has a four year mandate to integrate services by closing and merging hospitals and to divert funds to primary care.</p>

## Appendix 4

### Regionalization Structures and Their Responsibilities in Health Systems Across Canada April 1999

Province	Quebec	New Brunswick	Nova Scotia	Prince Edward Island
<b>Ministries</b>	Ministère de la santé et service sociaux	Health & Community Services	Dept. of Health	Dept. of Health & Social Serv.
Regionalized Bodies	<p><u>Régies régionales</u> 18 - The <i>régies</i> ensure that complementary and integrated health and social services are provided by facilities in the regions.</p> <p><u>Facilities:</u> 1.Hospitals 2.Care Centres for Youth 3.Long Term Care Centres 4.Rehabilitation Centres 5.CLSCs (<i>Centres locaux de services communautaires</i>) -each facility or group of small similar facilities within a region, has a Board of Directors.</p> <p>There are no <u>Community Health Boards</u>.</p> <p><i>Régies are directly accountable to the Ministry.</i></p> <p><i>Facilities are accountable to the régies.</i></p>	<p><u>Region Hospital Corporations</u> 8 Six regions have one English speaking RHC each. One region has <i>one</i> French and <i>one</i> English speaking RHC.</p> <p>-responsible for the governance of their region's hospitals and related institutions, Addictive Services Programs, and the Extra-mural Program. The Extra-mural program provides comprehensive home care including nursing, physiotherapy, respiratory therapy, and occupational therapy to patients in the community.</p> <p>There are no other <u>intermediary boards or corporations</u>.</p> <p><i>RHCs are directly accountable to the Ministry.</i></p>	<p><u>Regional Health Boards</u> 4 -have the responsibility and authority to govern, plan, manage, deliver, monitor, and evaluate health services within their region.</p> <p><u>Non-Designated Organizations</u> 4 -health care facilities not presently under the jurisdiction of Regional Health Boards: 1.Queen Elizabeth II Health Sciences Centre 2.IWK/Grace Health Centre for Children, Women, and Families 3.Nova Scotia Hospital 4.Cape Breton Health Care Complex.</p> <p><u>Community Health Boards</u> 33 -provide community health plans to the RHBs to be incorporated into regional health plans which are then integrated at the provincial level</p> <p><i>RHBs and NDOs are directly accountable to the Ministry.</i></p> <p><i>CHBs are directly accountable to RHBs.</i></p>	<p><u>Regional Health Boards</u> 5 -responsible for the delivery of all health and social services.</p> <p>There are no <u>Community Health Boards</u>.</p> <p><i>RHBs are directly accountable to the Ministry.</i></p>

# **Appendix 5**

## **Terms of Reference**

### **Regionalization Review Task Force**

#### **PURPOSE:**

Reporting to the Minister of Health, the purpose of the Task Force is to review and assess the current approach to regionalization in Nova Scotia, recognizing that regionalization is still very new. The Task Force will put forward recommendations, strategies and options for a regionalized health care delivery system that:

- values local involvement in decision-making and is responsive and accountable to local communities, including in the governance and management of hospitals;
- ensures consistency and coordination between and across communities;
- has appropriate, clearly-defined, distinct and mutually supportive roles and responsibilities for CHBs, RHBs, NDOs and the DOH;
- maximizes the public's access to health care services;
- optimizes the use of public dollars spent on health care; and
- is built on appropriate health care region boundaries.

#### **EXPECTED OUTCOMES:**

By **December 15, 1998**, the Task Force will:

- Prepare a workplan, including a consultation and communication strategy.
- Develop an understanding of the existing management and governance structures and the rationales behind regionalization.

By **Spring, 1999**, the Task Force will:

- Review and assess the current governance and management of the regional system in accordance with the purpose of the Task Force (identifying current issues, strengths/weaknesses, opportunities for system improvements).
- Provide findings, recommendations and options for addressing identified areas of concern or realizing opportunities for improvement.

## **MEMBERSHIP**

The membership and Chairperson as appointed by the Minister of Health.

## **MEETINGS**

It is expected that meetings will consist of full-day sessions on a weekly or bi-monthly basis. The Department will cover the cost of meeting space, meals, accommodation and transportation.

## **MINUTES**

Minutes will be recorded and distributed by support staff provided by the Department of Health. Upon approval of the Task Force the Minutes will be considered public.

## **DECISION-MAKING**

Decision-making will be by consensus.

Approved by:        Original Signed By Hon. Jim Smith  
                             Hon. Jim Smith  
                             Minister of Health

## Appendix 6

### Work Plan of the Minister's Task Force on Regionalized Health Care

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## Introduction

In June 1998, government members supported a resolution in the provincial legislature requesting the creation of a task force to review the current regionalized structure for health care delivery in Nova Scotia. The Task Force was appointed by the Minister of Health in October 1998 and will report to the Minister in June 1999 with recommendations, strategies and options for improving Nova Scotia's health care delivery system.

## Key Questions to be Addressed by the Task Force

The Task Force will attempt to address each of the following questions in its final report to the Minister of Health. What should be the health service delivery objectives of Nova Scotia's regionalized health care system? What recommendations should be made to advance these objectives?

! What should be the roles, responsibilities, accountabilities and inter-relationships of each of the key players (organizational structures) in the existing system<sup>2</sup>:

- ! Regional Health Boards (RHBs)
- ! Community Health Boards (CHBs)
- ! Non-Designated Organizations (NDOs)
- ! Department of Health (DOH)

What structural or governance changes are necessary to accomplish this?

! Are RHBs appropriately representative of the local communities and key stakeholders they serve? If not, how should membership or structure of RHBs and/or CHBs be changed?

! Is the current geographic delineation of health regions appropriate and efficient in terms of geographic area, population size and manageability? Do we have the right number of RHBs and CHBs now? If not, recommend changes.

! Should the approach to governance, management and service delivery be the same in all regions? What areas, if any, require a consistent approach?

What has been the impact of regionalization on health care delivery to Nova Scotians? What improvements can be recommended?

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<sup>1</sup>It is understood that the Task Force is free to recommend a different system, different roles, and/or different players, based on its findings.

- ! Recognizing that regionalized health care service delivery is still relatively new in Nova Scotia, what have been the major obstacles or challenges thus far? What have been its major strengths?

## **Major Elements of the Work of the Task Force**

The Task Force will employ a variety of methods of gathering information to answer these questions:

Requesting appropriate statistical and financial information from the Department of Health;

Inviting written submissions from advocacy and other groups, health professional organizations, health boards, and the general public;

Conducting surveys and focus groups to solicit opinion from health board members, health care providers, health care administrators and managers, health care consumers and the general public;

Holding public meetings to solicit and gauge opinion on a range of topics dealing with the regionalized health care system.; and

Inviting presentations to the Task Force the authors or sponsors of selected written submissions, subject to the collective discretion of the Task Force.

The Task Force intends to retain the services of a team of consultants to perform the survey and focus group work. Through the assistance of a consulting firm, the Task Force will survey all board members of RHBs, CHBs and NDOs. In addition, a statistically significant sample of health care providers, administrators, managers and consumers will be surveyed in each of the four regions. The consultant will also conduct at least 2 focus groups in each region, and may also conduct focus groups composed of members of other key stakeholder groups, subject to the direction of the Task Force. The Task Force will meet at least bi-weekly for the duration of its mandate and will often begin its meetings with a presentation and discussion.

## **Tentative Time Frame for the Work of the Task Force**

The following schedule of activity is proposed:

- ! December 17, 1998 Tender Closes on RFP for Consultants re. Survey Work
- ! January 4, 1999 Request for Public Submissions to the Task Force
- ! January 7, 1999 Tender Awarded for Survey Work
- ! January 29, 1999 Headline for Receipt of Written Submissions
- ! February 1, 1999 Survey questionnaires begin
- ! February 26, 1999 Surveys returned for analysis
- ! March, 1999 Focus Groups in each region for targeted stakeholders
- ! April, 1999 Public Forums in each region
- ! May 15, 1999 Consultant's final report due to Task Force
- ! June 30, 1999 Task Force Report due to Minister of Health

## Appendix 7

### Documents Reviewed by the Minister's Task Force on Regionalized Health Care

*\* Does not include correspondence or materials circulated at the meetings*

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- *An Act to Establish Regional Health Boards, Bill 95, June 30, 1995*
- *Accountability in Nova Scotia's Health System, 1997*
- *Nova Scotia's Health Regions and a list of Community Health Boards, Health Care Facilities, Nursing Homes/Homes for the Aged*
- *Nova Scotia's Blueprint for Health System Reform, The Minister's Action Committee on Health System Reform, 1994*
- *From Blueprint to Building, Renovating Nova Scotia's Health System, 1995*
- *From the Ground Up, Community Health Board Development in Nova Scotia, 1994 - 1997*
- *The Effective Not-For-Profit Board: Governance of Not-for-Profit Organizations. Deloitte & Touche, 1995*
- *Report of the Regionalization Assessment Team, British Columbia, 1996*
- *Regionalization of Health Care Systems in Canada, Nova Scotia Department of Health, 1997*
- *Health Care Update: Regionalization, Nova Scotia Department of Health, 1998*
- "The Benefits and Risks of Regionalization", an appendix from *How are Health Reforms Affecting Seniors*. National Advisory Council on Aging, 1998.
- *Getting Started: A Resource for Community Health Planning, Nova Scotia Department of Health, 1996*
- Excerpt from Nova Scotia Estimates, Health Sector, 1998 - 99
- Report of the Auditor General, Nova Scotia Chapters 11 and 12, 1998
- *Crisis in Vision Loss, Presentation to Department of Health, R. LeBlanc, MD, January 1999*
- *Devolving Authority for Health Care in Canada's Provinces - Four articles by Jonathan Lomas, MA, John Woods, BSc, Gerry Veenstra, MA, Canadian Medical Association Journal, March 15, 1997;156(6)*

- *PEI System Evaluation Project, A Brief Overview*, Menna MacIsaac, Nova Scotia Department of Health, 1998
- *The Impact of Regionalization on a Surgery Program in the Canadian Health Care System*, Stewart M. Hamilton, MD; Shaunne LeTourneau, MN; Ellen Pekeles, MHA; Don Voaklander, PhD; D. William C. Johnston, MD, *Archives of Surgery*, 1997; 132: 605 - 611
- *Nova Scotia Student Drug Use*, Nova Scotia Department of Health, 1998
- Health Services Review. Report of the Committee, New Brunswick, 1999
- Nova Scotia House of Assembly of the Standing Committee on Public Accounts, QE II Health Sciences Centre, Wednesday, January 27, 1999
- Western Region CHB Community Health Plans 1998/99
- *Building New Relationships: Hospital Foundations in a Regionalized Health System* April 1997, Karen Pyra, Nova Scotia Department of Health
- *Regionalization and Hospital Utilization: Alberta 1991/2 - 1996/7* L. Duncan Saunders, MBChD PhD; Kyung S. Bay, PhD; Arif A. Alibhai, MHSA, Healthcare Management Forum
- *The Health and Cost Effects of Substituting Home Care for Inpatient Acute Care: a Review of the Evidence*, Lee Soderstrom, PhD; Pierre Tousignant, MD, MSc; Terry Kaufman, LLB, *Canadian Medical Association Journal*, April 20, 1999; 160 (8)
- *Integrating Palliative Care in Nova Scotia: Discussion Document*, The Palliative Care Working Group, 1998

## **Appendix 8**

### **Consultants Retained by the Minister's Task Force on Regionalized Health Care in Nova Scotia**

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#### **Corporate Research Associates**

Through survey research, assisted the Task Force in collecting and documenting the opinions and experiences of key stakeholder groups across the province of Nova Scotia in terms of the impacts and consequences of the regionalized approach to health care governance, management and service delivery.

#### **Griffiths Muecke**

Provided external facilitation for the public meetings conducted by the Task Force in eight locations across the province.

#### **Proactive Group of Companies**

Facilitated discussions and deliberations of task force members in several day-long meetings immediately prior to the drafting of the Task Force report.

## **Appendix 9**

### **Meetings Held by the Minister's Task Force on Regionalized Health Care in Nova Scotia**

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May 3, 1999	Public Meeting, Middleton, NS
May 4, 1999	Western Regional Health Board and Senior Management, Cornwallis, NS
May 4, 1999	CHBs in Western Region, Liverpool, NS
May 4, 1999	Public Meeting, Liverpool, NS
May 10, 1999	Board and Senior Management of Cape Breton Healthcare Complex, Sydney, NS
May 10, 1999	Public Meeting, Sydney River, NS
May 11, 1999	Eastern Regional Health Board and Senior Management, North Sydney, NS
May 11, 1999	CHBs in Eastern Region, Port Hawkesbury, NS
May 11, 1999	Public Meeting, Port Hawkesbury, NS
May 12, 1999	Public Meeting, Pictou, NS
May 13, 1999	Northern Regional Health Board and Senior Management, Truro, NS
May 13, 1999	CHBs in Northern Region, Truro, NS
May 13, 1999	Public Meeting, Springhill, NS
May 17, 1999	Public Meeting, Halifax, NS
May 18, 1999	Central Regional Health Board and Senior Management, Dartmouth, NS
May 18, 1999	CHBs in Central Region, Dartmouth, NS
May 20, 1999	Public Meeting, Fall River, NS
May 21, 1999	Board and Senior Management of IWK Grace Health Centre, Halifax, NS
May 28, 1999	Board and Senior Management of QE II Health Sciences Centre, Halifax, NS
May 31, 1999	Board and Senior Management of The Nova Scotia Hospital, Dartmouth, NS

## Appendix 10

### Presentations to Minister's Task Force on Regionalized Health Care

<b>Date</b>	<b>Presenter(s)</b>
Nov. 13, 1998	Menna MacIsaac, Director, RHB Secretariat, Department of Health
Nov. 20, 1999	Mildred Royer, former Deputy Minister, Department of Health
Nov. 29, 1998	Dr. David Elliott, Medical Consultant, Department of Health
Dec. 18, 1998	John Hamm (Leader of Progressive Conservative Party) and George Moody (Progressive Conservative Party Health Critic)
Jan. 7, 1999	Betty Attenborough, Reproductive Care Program Coordinator, Ted Luther, Obstetrical Co-Director (RPC), Alec Allen, Neo-natal Co-Director (RPC)
Jan. 7, 1999	Robert Chisholm (Leader of New Democratic Party) and Maureen MacDonald (New Democratic Party Health Critic)
Jan. 22, 1999	Dr. Ina Cummings, Director of Palliative Care, QE II Health Sciences Centre Dr. Gerri Frager, Director of Palliative Care, IWK-Grace, and Sandra Cook, Policy Analyst, Acute Care,(Palliative Care) Department of Health
Feb. 19, 1999	Barry MacMillan, CEO, Central Regional Health Board
Feb. 19, 1999	Victor Maddalena, CEO, Western Regional Health Board
Feb. 19, 1999	John Higgins, CEO, Eastern Regional Health Board
Feb. 19, 1999	Anne McGuire, Executive Director, The Nova Scotia Hospital
Feb. 26, 1999	Rick Nurse, CEO, IWK Grace Health Centre
Feb. 26, 1999	John Malcom, CEO, Cape Breton Healthcare Complex
Feb. 26, 1999	Bob Smith CEO and Maura Davies, QE II Health Sciences Centre
Feb. 26, 1999	Dr. David Rippey, CEO, Northern Regional Health Board
March 12, 1999	Dr. Nuala Kenny, Deputy Minister, Department of Health
April 9, 1999	Kristin Schmitz, Administrator, St. Vincent's Guest House
April 9, 1999	Lorna Crocker-McIntosh, Administrator, R.K. MacDonald Nsng. Home
April 9, 1999	Eleanor MacDougall, A/Director, Home Care, Department of Health
May 21, 1999	Dr. Mike Murphy, Executive Director, Dr. Ed Cain, Medical Director, Mike McKeage, Director of Operations, EMC Inc. Emergency Health Services, Department of Health
May 28, 1999	Bill Twaddle, Director, Mental Health, Dr. John Campbell, Services Program Planner, Mental Health. Deptment of Health

## **Appendix 11**

### **Biographical Sketch Members of Minister's Task Force on Regionalized Health Care in Nova Scotia**

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**Cheryl Barker** lives in Curry's Corner, Hants County and is Unit Coordinator, OPD Emergency, Ambulatory Care, and Day Surgery, at the Hants Community Hospital. Ms. Barker is a Registered Nurse and a Certified Emergency Nurse having received her training in Windsor, N.S. She has served on the Government Task Force on Abuse towards Women and Children, the SOS Committee, and was a representative for the Labor Adjustment Strategy. Her contributions to the Nova Scotia Nurses Union are numerous having worked on the Provincial Constitution Team, the Provincial Resolutions Team and the Provincial Negotiating Team.

**Doug Clarke** resides in Halifax and is currently Chief Executive Officer of the Medical Society of Nova Scotia. Mr. Clarke obtained a Bachelor of Commerce from St. Mary's University and a Diploma of Chartered Accountancy. He was Budget Coordinator at Victoria General Hospital, and a Chartered Accountant at Touche, Ross & Co. prior to joining IWK Grace in 1985. During his twelve years at IWK Grace Mr. Clarke served as Vice President of Finance and Information Systems and also held the positions of Vice President, Corporate and Chief Financial Officer. In 1991 and 1992 he was the Acting President and CEO at IWK Grace Hospital. Mr. Clarke has served on various boards including the Nova Scotia Association of Health Organizations, the Nova Scotia Hospitals Protective Association, the Canadian Association of Pediatrics Hospitals and St. Vincent's Guest House.

**Dr. Richard Goldbloom**, a resident of Halifax, obtained his medical degree from McGill University followed by a Certificate in Pediatrics. He began his profession at Montreal Children's Hospital and was associate professor at McGill. Dr. Goldbloom moved to Nova Scotia in 1967 to be professor at Dalhousie University and Physician-in-Chief at the IWK. For the past thirty years he has been a distinguished lecturer to over seventy organizations around the world. Dr. Goldbloom has also been a director on numerous health, academic, editorial and community boards. He received several awards such as the Queen's Jubilee Medal in 1978 and the Confederation Medal in 1992. In 1987, he was honored for his work by being made an Officer of the Order of Canada. Dr. Goldbloom is a renowned author, having published over one-hundred and thirty original papers, twenty-one textbook chapters, and four medical textbooks. At the present time, he is professor of Pediatrics at Dalhousie University, a consultant for two health institutions, a contributing editor for a pediatric journal and serves on various boards and committees.

**John J. Henderson** lives in River John, N.S. and is currently a member of the Chignecto-Central Regional School Board. He obtained his Bachelor of Arts and Bachelor of Education degrees from Acadia University and for thirty-four years held the positions of teacher, principal and guidance counselor in the school system. Since retiring, Mr. Henderson has been active in his community as municipal councillor for the County of Pictou, member of Municipal and District School Boards, the Aberdeen Hospital Board, the Sutherland Harris Hospital Board, and the Nova Scotia Union of Municipalities Provincial Executive. He was also a member of the Blueprint Committee on Health System Reform, and member of the Northern Regional Health Board.

**George William Kyte** is a native of St. Peter's, N.S. He is a professional engineer, with an Engineering Diploma from St. Francis Xavier University and a Bachelor's Degree in Mechanical Engineering from TUNS. His career began in the oil industry in Calgary and changed to the world of business administration after he obtained a Diploma in Business Administration from the University of Toronto in 1962. He joined the Business Development Bank of Canada where he provided advice and financing to small and medium sized businesses in various postings across Canada, at the branch, regional and executive levels. He retired to St. Peter's in 1995 where volunteers in numerous organizations such as the Strait-Richmond Community Health Board, the Dr. W.B. Kingston Memorial Clinic, the Canadian Cancer Society, and the Richmond County Senior's Council.

**Gordon MacInnis** lives in Glace Bay, N.S. He graduated from Mount Allison University in 1984 with a Bachelor of Commerce Degree and received his Chartered Accountant designation in 1986 while working with KPMG. In 1998, Mr. MacInnis began his public sector career as Town Manager for Glace Bay. In 1994 he joined the senior management team of the Cape Breton Regional Municipality (CBRM) which was responsible for the initial design and implementation of the first regional government structure in Nova Scotia. Mr. MacInnis is currently the Deputy Chief Administrative Officer of the CBRM where he is responsible for long-term financial planning, strategic management initiatives. A strong proponent of public sector reform, Mr. MacInnis has served as CBRM administrative lead on a number of initiatives such as the current Municipal/Provincial Roles and Responsibilities Review, the Department of Justice (DOJ) *White Paper on Policing*, the UNSM/DOJ Police Advisory Committee, the Regional Library Funding Review Committee, and the new *Municipal Government Act*.

**Kathleen McIntosh** lives in Sydney, N.S. and holds a Bachelor of Science degree in Home Economics with a major in nutrition. She has held the positions of teacher, principal and consultant with the Department of Education and retired after being an inspector of schools for Cape Breton, Northside Victoria and Inverness. Since her retirement, Ms. McIntosh has volunteered on boards of Transition House, the Casket Newspaper, Sydney Day Care, and Cairdiel Place. She has also been the president of Antigonish Diocesan Society, chair of Parish Council and vice-president of Friends of Transition House.

**Dr. John McNab**, was born in Glasgow, Scotland; Dr. McNab is an honors graduate of the University of Toronto Medical School, completed residency training at Dalhousie University and is a Fellow of the College of Family Physicians of Canada. For twenty years, he has had a busy family practice in Fall River, Nova Scotia with a special interest in obstetrics, palliative care and counseling. He is a Lecturer at Dalhousie Medical School and teaches undergraduate students and residents in the areas of medical ethics, “death and dying”, interviewing and “Family Practice” skills. As well, he is a past president of the Nova Scotia College of Family Physicians, has been a member of Provincial Task Forces on Nursing and Nurse Clinicians, an Examiner in the national examination in Family Medicine, and member of the editorial advisory board of Maritime Drugs and Therapeutics. He is founding board member of “His Mansion”, a rehabilitation farm for troubled youth in rural P.E.I. John is active in his community and church, in which he is an elder and lay preacher. He maintains an avid interest in theology and English literature. He and his wife Marion and their four children live “out in the country” in Oakfield, and enjoy hiking, skiing, water sports, camping, travel and gardening.

**Keith Menzies** is currently administrator of the Ocean View Manor, a Home for the Aged in Eastern Passage, N.S. He had previously served as administrator of Kings Regional Rehabilitation Centre from 1976 to 1992, and as Chief Financial Officer for the Flin Flon Hospital in Manitoba from 1972 to 1975. Mr. Menzies currently serves on the Joint Ministerial Committee on continuing care, the Central Region Continuing Care Council, and represents the continuing care sector senior management at the Central Regional Health Board level. He also serves on the board of NSAHO and the Canadian College of Health Services Executives. In addition, Mr. Menzies teaches at Dalhousie University in the School of Health Services Administration on topics related to financial and accounting management.

**Dr. Jim Perkin** is a resident of Wolfville, N.S. where he is currently chair of the Western Regional Health Board (WRHB). A native of England, he studied in Strasbourg, France and obtained a D.Phil from Oxford University. Following his ordination as a Minister in 1956 he served his church for six years before teaching the New Testament at the University of Edinburgh. In 1965, Dr. Perkin was appointed associate professor at the McMaster Divinity College in Ontario and subsequently moved to Acadia University where he held several head positions before becoming President and Vice Chancellor in 1982. Prior to his appointment on the WRHB, Dr. Perkin was president of the Gerontology Association of Nova Scotia, a member of the Board of Trustees of Eastern Kings Memorial Hospital, and a member of the Board of Directors of the Valley Regional Hospital Foundation. He is the author of fifteen books, editor of four books, and has written over four hundred chapters, articles, essays and reviews. Dr. Perkin was honored for his service to higher education in 1992 when he was awarded the Commemorative Medal for Canada’s 125<sup>th</sup> Anniversary.

**Cathy Randall** lives in Halifax where she is currently Employee Relations Officer with the Nova Scotia Government Employees Union (NSGEU). She graduated from the Camp Hill Hospital School of Nursing Assistants. Ms. Randall worked at the Queen Mary Veteran's Hospital in Montreal, the Victoria General Hospital in Halifax, the Women's Clinic, Keddy's Nursing Manor and St. Vincent's Guest House, and again at the Victoria General Hospital, prior to her position with NSGEU. She has held lead positions in numerous organizations such as being Halifax Director and President of the Nova Scotia Certified Nursing Assistant Association (NSCNAA), and Vice-President of the Halifax Chapter of CNAs. She has also served on the Nova Scotia Task Force of Nursing, and on the Minister's Action Committee on Health System Reform (Blueprint Committee).

**Sheila Scaravelli** is a resident of New Glasgow, N.S. where she is currently the Director of Patient Care Services at the Aberdeen Regional Hospital. Ms. Scaravelli obtained her Nursing Diploma in 1970 from the Victoria General Hospital, a Bachelor of Nursing from Dalhousie University, and Master of Education from St. Mary's University. Ms. Scaravelli began her career as a Registered Nurse at the Victoria General Hospital in 1970 and became Director of Nursing at Aberdeen Regional Hospital in 1993. Her professional and community involvement include being President of the Pictou County Chapter of the Registered Nurses Association of Nova Scotia (RNANS), second Vice-President of the RNANS, member and chair of the Board of Directors of the Tearmann Society for Battered Women, as well as member of the New Glasgow YW-YMCA.

**David Smith** lives in Dartmouth, N.S., and is a member of the Clinical Initiatives Group Ambulatory Care Re-Engineering Team at the Queen Elizabeth II Health Sciences Centre. Mr. Smith obtained his Diploma of Nursing from the Victoria General Hospital in 1979 and Bachelor of Nursing and Master of Nursing degrees from Dalhousie University. Mr. Smith has spent thirteen years as coordinator of the Male Sexual Dysfunction Clinic at the QEII Health Sciences Center. At the professional level, Mr. Smith has served on various patient, provider and education groups including the Halifax Area Ostomate Chapter, Cancer Support Groups, the Canadian Paraplegic Association Counselors, Public Health Nurses, Dalhousie University Human Sexuality Team, and Dalhousie University School of Medicine's Urology and Family Medicine Divisions.

**Roxanna Smith**, a resident of Lunenburg, N.S., is a member of the Canadian Association of Medical Radiation Managers. For a number of years she was Chief X-Ray Technologist, Director and Supervisor of Diagnostic Imaging at the Fishermen's Memorial Hospital. Ms. Smith has served on many committees including the Fishermen's Memorial Hospital Foundation, Quality Management, and Steering Committee-Standards of Practice. At the community level she is currently president of the Lunenburg Academy Foundation, Co-Chair of the Health Services Foundation of the South Shore, and a member of the School Advisory Council. Roxie, as she is better known, is also actively involved in church activities.

## **Appendix 12**

### **Department of Health Staff Support Minister's Task Force on Regionalized Health Care**

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Maria Lasheras

Menna MacIsaac

Rick Manuel

Heather Marsten