ABSTRACT

The health policy *New Directions* committed the British Columbia government to a population health perspective and extensive community involvement in the health services reform process. The policy envisaged elected citizen boards with authority to raise revenues and exercise a significant degree of local autonomy. Academic and public attention has been paid to the decision in November 1996 to collapse *New Directions'* two-tier governance structure into a single level. Less attention has been paid to the profound changes that occurred prior to the government's reversal on the question of governance. This paper focusses on those changes. During the critical three years between the 1993 launch of the reform and its formal revision in 1996, the government's positions on elections, taxation power, local autonomy and scope of action for regional boards all changed. Those changes marked a retreat from political accountability to the community and an advance towards managerial accountability to the government.

ABRÉGÉ

La politique de santé « New Directions » avait engagé le gouvernement de la Colombie-Britannique dans une perspective de santé de la population et de participation intensive de la communauté au processus de réforme des services de santé. La politique prévoyait l'élection de conseils de citoyens dotés des pouvoirs de générer des revenus et d'exercer un niveau significatif d'autonomie locale. L'attention académique et publique a été attirée, en novembre 1996, sur le fait que la structure d'autorité prévue dans « New Directions » avait été réduite de deux niveaux à un seul. Moins d'intérêt a été porté aux changements profonds qui se sont produits avant que le gouvernement ne révisé la structure décisionnelle. Cet article se concentre sur ces changements. Pendant les trois années critiques entre le lancement de la réforme en 1993 et sa révision formelle en 1996, le gouvernement a changé sa position au sujet des élections du pouvoir d'imposition, de l'autonomie locale et de la portée des actions des comités régionaux. Ces changements ont marqué un recul au plan de la responsabilisation politique vis à vis de la communauté et un progrès de la responsabilisation de l'administration vis à vis du gouvernement.

British Columbia's Health Reform: "New Directions" and Accountability

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The New Democratic government announced the policy of *New Directions for a Healthy British Columbia*¹ in February 1993. The policy statement was in response to the report of the *Royal Commission on Health Care and Costs*² prepared for the previous Social Credit administration and presented to the new NDP government shortly after its election in 1991.

As would be expected with any government policy statement, *New Directions* contained ambiguities and some apparent contradictions. Those ambiguities and contradictions reflect the strategic, symbolic and substantive purposes of policy.^{3,4} They are also products of authorship by committee.

Ambiguities included the absence of any definition of "health" or "health services" and imprecise use of terms such as "population health" and the "determinants of health." Contradictions included commitments to the principles of universal publicly funded medicare (especially comprehensiveness and access) in the context of reducing health care costs and reorienting the health system towards a population health perspective. Strategic elements of the policy included a range of political promises, notably commitments to the health care unions that working conditions of health providers would be improved. Symbolically, the policy wrapped itself in the flag of medicare.

Yet taken as a piece, the perspective of *New Directions* was very clear. The intent

was to devolve substantial power over health services to citizens at the community level, not only to counter the power of the health professional elites, but also to foster a community orientation to wellness. The explicit intent was to build a constituency of support behind a broader concept of health, thereby engaging the local authorities in reforming not only health care services but also the social and economic conditions that prevailed in their communities.

From *New Directions'* perspective, the community should be responsible for, and be granted the power to, develop in accordance with its own needs and values. Democratic community development was linked to the idea that an active citizenry combined with collaboration among institutional actors would foster a healthy community, which in turn would provide the social and economic environment necessary for healthy individuals. The policy assumed circumstances would also be created whereby health care services would continue to be seen as essential, but no longer the dominant, elements within health services and health-related activities. Those circumstances would, it was hoped, encourage a mindset of parsimony with regard to health care utilization.

The ideas of *New Directions* were bolstered by supportive institutions. A two-level governance structure of Community Health Councils (CHCs) and Regional Health Boards (RHBs) would force community accountability and responsiveness, as well as inter-sectoral and inter-community collaboration. Inter-sectoral collaboration would be achieved through integration of a broad range of services at the community level under the control of the CHC; inter-community collaboration by requiring

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community plans and expenditures to be vetted by representatives of all of the communities within the region (RHB). Local governments were mandated partners through legislated representation on CHCs.

Regionalization *per se* was not a novel health policy idea. Every Canadian province except Ontario had, by 1993, embraced a form of regionalization for its health care system. The NDP government in Saskatchewan as of 1995 had pioneered a reform based on elected regional health authorities.⁵ *New Directions'* novelty lay in the goals regionalization was intended to achieve. Whereas regionalization was generally adopted elsewhere for reasons of efficiency, the British Columbia provincial government saw regionalization (combined with a high degree of delegation to the local health authorities) as presenting an opportunity to reduce the power and authority of ministry bureaucrats, health care managers, and especially health care professionals. Authority over the provision of services could be brought "closer to home" and bureaucratic and professional barriers could be brought down through a strategy of regionalization. A key policy objective was to improve accountability of health care professionals and providers through strengthened democratic accountability at the community level.

New Directions understandably set off a policy controversy. The B.C. Medical Association, the B.C. Health Association and the Union of B.C. Municipalities fiercely opposed it. Ministry officials and facility-based managers worked to conserve their respective positions as organizational forms changed in consequence of the policy. Following their 1996 re-election, the NDP government reviewed *New Directions* and in November of that year formally abandoned it. *New Directions* was replaced by *Better Teamwork*. Most visible among the substantive policy changes was the elimination of the two-level governance structure. Less apparent were the changes that occurred in the lead-up to *Better Teamwork* – changes that had profound effects on accountability.

During the critical three years between the 1993 birth of *New Directions* and its funeral rites in November 1996, the

British Columbia government's position on elections, taxation, local autonomy and scope of action for health authorities changed. The direction of change in each instance was consistent with the progressive abandonment of the reform principles inherent in the original policy statement. Movement was away from a perspective centred on citizen empowerment toward a policy focussing on the accountability of boards and councils to the Ministry of Health. Bound up in that change was a retreat from political accountability to the community and an advance toward managerial accountability to the ministry.

Political accountability refers to being held answerable for one's actions – being held to account. It includes taking direction from and being sanctioned by those to whom one is accountable. Managerial accountability refers to spending money in accordance with accepted accounting practices, providing services as efficiently as possible, and obtaining the intended results.⁶⁻⁸

The changes were not merely organizational, nor were they merely the result of conflicts between the goals of improving health system management and improving the accountability of health service professionals and providers. They marked a change in substantive policy. Local accountability and community empowerment are bound up conceptually and normatively with a community health perspective on health.⁹ The changes to governance arrangements are also bound up with issues of power and control. In principle, there can be no accountability without control. A body cannot be held accountable for something that is beyond its power.⁶ Accountability also requires that those to whom a body is accountable have the means to hold that body to account. Holding to account entails several conditions, chief among them knowledge of the actions taken and the reasons for those actions. Holding to account also requires, in principle, the prospect of sanctions by those to whom accountability is owed.⁸

Citizen boards were explicit attempts to make health professionals, providers and managers more accountable to the public. Accountability to the public requires transparency of board processes, full disclosure

of the board's actions, reasonable public notice of meetings, opportunities for the public to seek reasons for the board's actions, as well as ready public access to background information. Those basic conditions were recognized at the outset by the government and were mandated in directions given to interim boards and councils.¹⁰

However, those basic conditions are not jointly sufficient for accountability to the community. They do not assure adequate board control over the areas it is formally responsible for, nor are they jointly sufficient for the public to hold the board to account. Election of board members is important in this context. Elections serve not only to increase the legitimacy of the board members in the eyes of the public and the health care providers, but also increase the accountability of board members to the local citizenry. Enhanced legitimacy enhances authority, which in turn strengthens control. Elections also force the giving of reasons, explanations of actions by incumbents and rationales for planned actions by aspirants. Further, elections give the public a means of sanctioning board members by defeat at the polls.

While a policy based on community development and community health principles would suggest public elections of boards and councils (reserving room for some appointments to ensure all key constituencies are represented), the government first deferred and then abandoned the idea of elections. There were several reasons for the reversal. The government was concerned that the general public might support traditional health care services and their providers. Democratizing decision making could thus result in greater rather than less pressure for expanding conventional health care services. The government was also concerned that low election turnouts might allow capture of boards and councils by special interest groups such as anti-abortionists. Further, the energy and confusion generated by the grassroots community development process fuelled the growing concern by government and managers over their control of the process. Finally, the government shifted its perspective on health services following the surgical and cancer care

waiting list crisis that erupted in 1995. Adverse publicity served to transform the key policy problematic from improving health outcomes for the population to improving public access to conventional health care services.

The change to fully appointed bodies had several implications. First, political appointment blurred the function of boards with the responsibilities of government through the creation of relationships of agency and subsidiarity. Apart from the appearance of patronage (and political motivation more broadly) created by ministerial appointment, the approach linked the board member to the Minister, and thereby to the Minister's responsibilities to Cabinet and the legislature. From the perspective of administrative law, the member was in an agency relationship to the Minister, acting formally on the Minister's behalf and serving at his/her pleasure. The appointed board as a whole reflected the principle of subsidiarity – it was the creature of and was accountable to government. In short, authority was not devolved to the boards and councils, as it would be through the principle of public elections, but delegated to them by the provincial government.

In addition to the principle of appointment, there were issues of practice. What criteria should be used for the selection of board members and how could they be defended as legitimate? In this regard, the B.C. auditor general, George Morfitt, criticized the government for having no rational criteria for selection. He commented "there was no documentation to identify competencies required by each individual or the governing body as a whole." Without it, Morfitt concluded, there was no foundation for board accountability.¹¹ The media concurred, reporting that board positions were filled on political whim.¹²

Board members were not only drawn into politics; the approach under *Better Teamwork* drew managers into policy. The "new public management" called for appointing visionary leaders as chief executive officers, thereby blurring management's role with that of the board. The "Carver Model" of board governance (imposed by the ministry on the boards) offered an expansive role to the chief executive

officer and a truncated one for the board.¹³ It facilitated the migration of management into governance, while enjoining boards to steer clear of management. The model rested on the faulty assumption that governance is about normative matters whereas management is technical and "values-free". The public role of CEOs, their role in the distribution of resources, and their responsibility for organizational climate are all inherently normative. They "are not only or simply aspects of the managerial repertoire, but are fundamentally concerned with the allocation of values."¹⁴ In short, a government-appointed board operating under the Carver model was encroached upon from both the political and managerial sides. Such boards have the misfortune of occupying what Anne Mills described as the "twilight zone in public administration."¹⁵

The government's growing emphasis after February 1994 on accountability for the results of health care spending exacerbated the issues of board accountability and control. The subordinate relationship to government and the emphasis on improving health care management operated hand-in-hand. Jointly, they reduced the board's public role in two ways. First, they limited public consultation partly because of the risk of consultations leading to conclusions inconsistent with government's preferred direction and partly because the public has little to offer with regard to improving management outcomes.¹⁶ As Ham and Best put it (in the context of the National Health Service's drive to outcomes-based cost-effectiveness), emphasizing the quality of health care management "means downgrading [the board's] role in providing a channel for public participation."¹⁷

Accountability to the public requires clear, publicly supported principles and goals. Those would normally be defined and gain legitimacy through local democratic processes, including elections of governors. The decision to appoint board members rather than elect (the majority of) them placed an enormous responsibility on the new boards to develop effective participatory mechanisms. Unfortunately, the narrow view of the governing bodies' role – improving management – makes both

the idea of and mechanisms for consultation problematic. The context for implementation made matters even more problematic – community activists and volunteers had been either sapped of energy or thoroughly alienated by the disintegration of *New Directions*.

Successive Ministers of Health had striven to use their powers of appointment to create boards that contained a cross-section of people from the community, with special attention paid to minorities such as Aboriginal people. While appointees were drawn from distinctive groups, they could not be said to represent them. There was no connection between board members and their "constituencies". Recent interviews determined that B.C. health board members regarded their role to be representative of the broader region.¹⁸ Lomas, Woods and Veenstra¹⁹ similarly found health board and council members across Canada generally regard themselves as representing the broader constituency of their community or region. Day and Klein⁸ found a similar perspective among (appointed) health board members in the United Kingdom. However, as Day and Klein noted, without specific mechanisms of consultation, the claim to represent the community is an empty one. A case study of B.C. health authorities found those consultative mechanisms to be missing.¹⁸

Taxing authority is closely linked to the elections and both relate to accountability.²⁰ Taxes and elections are linked by the constitutional principle of no taxation without representation. Taxation is linked to accountability by the public administration principle that a public body can only be fully accountable for spending if it has some responsibility for raising its own revenues.

Central governments everywhere are reluctant to give local authorities taxation powers other than property taxation. There are three reasons. First, governments do not wish to cede tax room to subordinate bodies. Second, property taxes are more readily set and collected locally because local conditions and property values vary. Third, property taxes are highly inelastic, and therefore do not give local authorities much capacity to expand public spending. However, property taxes are also charged

politically, and suggestions to change who may levy them at what rates are bound to be controversial. That was certainly true with the proposal that RHBs raise the 40% of local revenues required for hospital projects. The resistance by local government eventually forced the provincial government to back down.

The reversal brought fresh difficulties. The media claimed disconnecting spending and revenue powers undermined the accountability of health boards. "The people appointed to the new boards by the NDP government are now responsible but not accountable."²¹ Academic observers concurred. Severing the link between health service provision and local taxation was tantamount to converting the health boards into agents of the government.²² Most vocal in this regard were the same local governments that opposed fiscal independence for boards and councils:

The Province appears to be delegating responsibility for health care to communities but is retaining control over the expenditure of funds. This has the potential to create a situation that everyone wants to avoid; that of no clear accountability or responsiveness to either provincial or local priorities. This can produce a situation wherein:

- *local health bodies avoid being accountable to local publics by simply stating they did not receive adequate provincial funding to meet local priorities*
- *the Health Minister passes the responsibility to local bodies by saying that adequate funding, or the maximum available funding was provided for local priorities.*²³

Local autonomy also contracted sharply over the course of *New Directions'* implementation, and virtually vanished with *Better Teamwork*. In the period from February 1994 to November 1996, the encouragement of local diversity and experimentation in the context of substantial community control gave way to narrowly defined core services, outcome measures, and the provincial government's preoccupation with developing an accountability framework.

The range of programs and services for which the boards were responsible also

shrank over the three-year implementation period. Following the creation of the Ministry of Children and Family Services, the scope of programs was even smaller than the pre-reform cluster of Ministry of Health programs. By 1996, it comprised only hospital, continuing care and some public health services. Addiction treatment, community mental health, maternal and child public health, and school health services were among those transferred out of the health portfolio (and regional health authority control) to the Ministry of Children and Families. The potential for collaboration and new partnerships shrank along with the reduction in the scope of services under the health authorities' mandate.

In consequence of these changes, boards were increasingly enjoined by the ministry from 1995 onwards to express their responsibilities in terms of results achieved by health care spending. This was quite different from the 1993 emphasis on articulating responsibilities in terms of results for people. The new emphasis was on efficiency and effectiveness of services; the old was on aligning public expenditures with the needs of the community. The entire frame of reference changed to a managerial one from a political one. Importantly, the more emphasis that was placed on technical and managerial dimensions, the less the power and authority of the board and the greater the influence of management.²⁴ Thus *New Directions'* goal of holding management (and the providers) accountable to the public was subverted. That loss of political accountability to the community signaled a u-turn in *New Directions*. The innovative, reforming thrust of fostering a community health perspective was reversed and health service changes increasingly took the form of administrative reorganization. All that remained was confirmation of the new direction, a confirmation that took the form of abolishing the community health councils in November 1996.

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