



**STAFF REPORT TO THE PLANNING & PROTECTIVE SERVICES COMMITTEE
MEETING OF WEDNESDAY, FEBRUARY 22, 2006**

SUBJECT: Vancouver Island Health Authority's (VIHA's) Draft Five-Year Strategic Plan

PURPOSE/ISSUE:

To review VIHA's draft Five Year (2010) Strategic Plan released October 14, 2005. This report is a summary of a detailed report provided to VIHA on December 21st. VIHA agreed to review the detailed report and provide comments and clarification before this report went to Committee. This did not happen.

At the October 21, 2005 Joint Capital Planning Committee meeting in Nanaimo, VIHA agreed to present the Plan to each Regional District. VIHA's presentation to the CRD took place February 8, 2006, two weeks before the Planning & Protective Services Committee meeting.

Staff's detailed review of the Strategic Plan will be available at the Committee meeting.

HISTORY/ BACKGROUND:

As a summary of the more detailed staff report already provided to VIHA, this report is limited to a discussion of five major themes and observations. Attachment One is a statement of limitations of the review. Attachment Two includes some direct quotations from the Draft Strategic Plan to illustrate some of the major themes.

A. MAJOR THEMES/OBSERVATIONS

1. Imbalance in the System

The Plan attests to an imbalance in the provision of health services. Inappropriately high rates of use of hospitals are linked to deficiencies or shortages in community support and primary care for the elderly and the mentally ill.

Various statistics and comments are provided including 15% of hospital days spent by patients no longer requiring acute care (called Alternate Levels of Care [ALC] patients) occurring through 2003/04 with the South Island rate 28% higher than the provincial average.

VIHA's unpublished March 2005 Performance Report states that the "May Not Require Hospitalization rate *is particularly high for mentally ill patients* (50% higher than the provincial average), *reflecting the lack of community resources.*"

This imbalance creates significant inefficiencies in financial and operational terms. Hospitals are the highest cost location in the health system and unnecessary usage contributes to delays in access and treatment for acute patients, overcrowds emergency departments, not to mention hospitals being the wrong place for people with non-acute conditions.

2. Incomplete and/or Inaccurate Description of Social Determinants of Health

The Plan mentions that “health *is determined by a number of factors other than health services and that living and working conditions have a larger impact on people’s health than health services.*” The Plan could have offered more specific information on the relative influence of the major factors determining health. The Canadian Institute on Advanced Research estimated that 50% of health status is linked to social and economic conditions, 25% to the health system, 15% to biology and genetics and 10% to the physical environment.

The Plan goes on to describe that VIHA *needs to pay attention to the broad determinants of health and will work with community partners to implement prevention and protection programs to support residents in making healthy lifestyle choices.* Also, VIHA’s Wellness Plan is to *be built on the belief that individuals are ultimately responsible for their own health.*

In these statements VIHA favors the “behavioural approach” to health improvement and diminishes the “structural approach” which recognizes the primacy of social conditions as the main causes of “*unhealthy behaviors.*” The Plan does not adequately cover the link between health and social conditions; the growing inequality in society, unlivable wages, employment insecurity, homelessness or unaffordable housing and food and transportation access. International population health research shows that personal security through employment, livable wages, affordable housing and food and transportation security are preconditions to “choosing a healthy lifestyle.”

The recent study on childhood/youth overweight (Neighbourhood Socio-economic Status and the Prevalence of Overweight Canadian Children and Youth) is a good example of the play of structural factors and their influence on behaviours (see Attachment Two).

VIHA rightfully acknowledge that they are unable to independently affect the broader social determinants of health. With more and more research on the significance of social determinants, the time is right for serious public discussion and debate.

3. Service Integration – What Does It Mean

The Plan emphasizes the importance of integrating services as a means to improve access and patient flow. Integration is also the justification for the absence of individual sector plans (acute, home and community care, mental health, etc.).

Combining and coordinating the parts of a large and complex system (to make it a well functioning whole) is common sense. However, the Plan doesn’t offer any examples of which services are currently separate, why they should be integrated and what benefits are expected. Without these examples it is difficult to see how the system will be improved or to understand whether opportunities for improvement lie more in increasing the supply or reorganization of services in one or other of the sectors of the health system.

4. Detail, Substance and Evidence

The lack of information on “service integration” is typical of the lack of detail in the Plan. While a “high level” Strategic Plan might not be the right source of detailed information on the *seven critical issues and challenges* (see Attachment Three), *three goals* (see Attachment Three) or the *three overall goals and subsidiary strategic themes*, there are no other sources. Details should be available elsewhere in sector plans, infrastructure plans or implementation plans. However, there are no sector plans and infrastructure plans are not finished.

There are also questions of the accuracy of the Plan. One example is the Plan's projection of an additional 50 residential care beds and 70 assisted living units (total 120 units) in the Capital Region to 2008/2009. This contrasts with the January 2006 Request for Proposals for 215 residential care and 65 assisted living units (total 280 spaces). The numbers have changed significantly in the last four months?

There is also no financial information in the Plan. Again, this may be outside the Strategic Plan content but it should be disclosed somewhere. Information on current VIHA expenditures, the scales of financial pressures and fiscal sustainability, estimates of the cost to implement the Plan and the consequences of not carrying out the Plan, are all relevant to the public record.

The oft-asked question of the attainment of the provincial commitment for 5,000 residential care beds is impossible to confirm in the Plan. There is no clear information.

The Plan has very little historic or trend information to compare or set the stage for proposed changes. The intention to "significantly **expand home and community care**" and the recognition that "**the system doesn't work well for the elderly**" is arguably a correction to recent reductions in residential care and home support eligibility restrictions and the problems encountered over the last four years.

The Plan has numerous references to VIHA's performance including advancements in patient flow, quality, patient safety, appropriateness and innovation but rarely are they supported by measures to confirm the advancements. This information is included in other Plans but these are often not publicly released.

5. Public Confidence and Accountability

The Plan mentions the need for transparency and openness to the public, the need to continue to involve key stakeholders, where appropriate, regarding planning and delivery of health care and to build relationships through collaboration and sharing of knowledge and information.

Experience suggests that VIHA is not transparent and open to the public or key stakeholders. Examples of unreleased reports include the full March 2005 Performance Report and the March 2005 Draft Three-Year Home and Community Care Plan. Failure to release the March 2005 Performance Report (and similar reports) prevents a public accounting of whether VIHA's performance is improving or deteriorating.

From what we observe, there was no meaningful participation by the public or key stakeholders in the preparation of the Strategic Plan. If, as the plan states, VIHA is serious about building confidence in the health system it should survey the public and key stakeholders on their perception of VIHA's transparency/openness, collaboration and sharing of knowledge and information.

The review has covered the Plan and its content. There are a number of high level structural factors, which have not been covered in the Plan. The structural factors are included in Attachment Four.

ALTERNATIVES:

Not applicable.

FINANCIAL IMPLICATIONS:

Not applicable.

SUMMARY/CONCLUSIONS:

The Draft Five-Year Strategic Plan has much information but not enough detail to present a clear and convincing picture of the current health system, recent trends and its future direction. Strategic Plans, as high level organizational overviews, are usually based on more detailed component plans (dealing with individual health system sectors, critical issues or high risk populations). These component plans, usually developed with input from those participating in the provision of health services or affected by them, do not appear to exist. The January 2006 Request for Proposals for residential care and assisted living, at almost two and a half times the units identified in the October 2005 Plan, is an example of early divergence from the Plan and an observation of the foundations and accuracy of the Plan.

The five major themes and observations discussed in the report represent a snap shot of the Plan. An ***imbalanced health system*** with an overdependence on hospitals and its associated inefficiencies and is set to be rebalanced by increased home and community care services which had been previously reduced by VIHA. The influence of ***social determinants*** or social conditions is beyond the approach suggested by VIHA of supporting residents to make healthy lifestyle choices. Healthy behaviors are a product of living and working conditions and the attainment of reasonable individual personal security which are outside VIHA's mandate. The focus on ***integrating services*** is not clearly explained leaving questions as to what further gains will be made from more integration compared to increasing activities in some sectors or addressing social determinants.

The Plan mentions the need for transparency and openness to the public, the involvement of key stakeholders in planning and delivery of health care and relationships built on collaboration and sharing knowledge and information. There was no meaningful participation by key stakeholders and the public in the development of the Plan and three evening drop-in sessions with an individual write-in feedback process is arguably insufficient to engage those outside VIHA in a collaborative effort to improve the health system.

Finally, there are major structural issues (identified in Attachment Four) which define the governance and operation of the health system which should be addressed.

RECOMMENDATION:

That this report be accepted as information and forwarded to the CRHD Board for its information.

Jeremy Tate, Manager
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attachments: 4

COMMENTS: