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RESOURCE ALLOCATION DECISION-MAKING IN AN ONTARIO TEACHING HOSPITAL

by

Marianne Lamb

A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Graduate Department of Community Health
University of Toronto

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ABSTRACT

RESOURCE ALLOCATION DECISION-MAKING IN AN ONTARIO TEACHING HOSPITAL

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Marianne Lamb
Doctor of Philosophy
Graduate Department of Community Health
University of Toronto, 1997

Hospitals occupy an important position within the Canadian health care system and their services are highly valued by the public. As hospitals receive a substantial portion of the public funding allocated by governments to health care, and as governments increasingly seek ways to reduce public spending, attention has focused on how hospitals ought to make decisions about the allocation and use of the health care resources they receive.

The purpose of this study was to describe resource allocation decision-making in a Canadian hospital and to identify themes relevant to the process. The study was conducted using ethnographic methods to examine resource allocation decision-making in one Canadian teaching hospital over a period of approximately eleven months. There were three sources of data: hospital documents collected throughout the field study period, interviews of senior administrators, senior physicians and members of the board of trustees and non-participant observation at the hospital, most of which occurred at meetings of senior level decision-making groups.

Two major resource allocation processes were observed during
the field work: decision-making about the operating budget and
decision-making about the capital budget. Major themes in
allocating the operating budget were those of the central role of
senior administrators, evolving relationships, incremental
budgeting, soft information and professional judgement, power and
marginal changes in allocations and responses to fiscal stress.
Major themes in allocating the capital budget were roles, goals and
preferences, deteriorating relationships, capital budget components
and decision processes, power and capital allocations and responses
to fiscal stress. These two processes are described in detail and
analysis of the processes focuses on the research questions of who
makes decisions, how decisions are made and the reasons given for
resource allocation decisions.
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CHAPTER 1

INTRODUCTION

Health care is a major and valued component of Canadian society, a component funded to a great extent by public monies. In Canada therefore, governments make macroallocation decisions on the amount of public funds they devote to this component, as well as to other societal interests such as education, transport and social services. Provincial Ministries of Health must also make decisions about how to divide funds for health among the various types of health care services and institutions. Such macroallocation decisions involve politicians in considerations of societal priorities and priorities within health care (Blank, 1988). Microallocation decisions in health care refer to the allocation of available health care to individuals (ten Have, 1988), decisions that are generally considered to be the responsibility of medical practitioners and clinician managers, involving considerations of medical criteria (Darr, 1991). In a 1991 article, Martin Barkin, then Deputy Minister of Health in Ontario, questioned what was happening at the "medium level" of resource allocation decision-making, noting that "once the macro allocation is made, the government then transfers the bulk of the health allocation to the provider agencies and organizations which, in turn, decide how our health care dollars are actually spent" (p. 32).

Hospitals are major provider agencies within the Canadian system of health care. In terms of their operations, most
hospitals in Canada rely heavily on public funding, yet they seem to have considerable autonomy in the internal allocation and management of these funds. The question of how hospitals make resource allocation decisions was a compelling one to me, for it focused on a point midway between broad health policy and the delivery of health care services to individuals, a point that has received limited research attention. As Pondy (1970) and Pfeffer (1977) note, large organizations play a key role in the social and economic life of a society; the way in which they allocate their internal resources has an impact on that society. Lasswell (1958) defined politics in terms of "who gets what, when, and how". To the extent that organizations such as hospitals allocate public resources to various purposes, they implement health policy and are engaged to some degree in policy decision-making.

Resource allocation refers to the assignment of a discrete amount of funds, personnel, equipment, space or other asset to a set of specified purposes. For example, in the context of a teaching hospital, resources are devoted to the provision of many different types of patient care services, the support of research activities and the teaching of students in the health professions. Three groups have traditionally been viewed as central to decision-making in hospitals: the governing board, the senior administration and the medical staff (Provan, 1991). These groups make decisions on resource allocation that are reflected in the operating and capital budgets, which represent intentions, and in actual allocations, as recorded in year-end reports. Although
there have been a number of studies of various aspects of resource allocation decisions in hospitals and other public institutions, no in-depth examination of the process of decision-making by these senior groups in Canadian hospitals was identified. This study was designed to provide a micro view of such a mesoallocation process.

1.1 Purpose and Research Questions

The purposes of the research are to describe the process of resource allocation decision-making at the senior level in one hospital over an extended period of time and to identify themes emerging from the data. The intent in conducting this study is to develop an understanding of such decision-making in a hospital and how it takes place, a understanding based on a broad picture of the process within the life of an organization.

In qualitative research, although one starts with a set of research questions, new questions arise and earlier ones may be reformulated as the data collection proceeds. The following questions guided the initial phase of the research:

1. Who? Who are the key actors with regard to resource allocation decisions in hospitals? What roles do these actors play in decision-making?
2. What? What kinds of resource allocation decisions are made at the senior level in hospitals? Does decision-making vary by the type of decision made? What kinds of problems are encountered during decision-making?
3. How? What procedures are used in making resource allocation decisions? Are there identifiable stages in
decision-making? What kinds of information are used in making decisions? How are problems or disagreements resolved?

4. Why? What reasons are given for the resource allocation decisions made? What goals, values, arguments and principles are put forward on behalf of various courses of action?

1.2 Context of the Study

In Canada, the provincial Ministries of Health fund hospital operating budgets and approve of, and largely fund, any capital projects (Evans, 1984). The study took place at a time when provincial governments were expressing alarm about the growing percentage of provincial budgets that were devoted to health care; in Ontario, public spending in this sector increased over a ten-year period from 27% to 33% of all government expenditures (Conjoint Review Committee, 1988). As expenditures for hospitals represented a substantial portion of the total health care budget, many governments had instituted policies designed to limit growth in this portion. During the late 1980's and early 1990's, provincial Ministries of Health engaged in studies of their health care systems and considerable scrutiny of hospital financing (Conjoint Review Committee, 1988; Mhatre & Deber, 1992).

In 1989, the Ontario Ministry of Health (MOH) had signalled its intent to move away from the traditional system of funding hospitals and introduced a "transitional funding initiative" designed to tie funding to the types of patients treated. It was believed that such a system would create an incentive for cost-effective use of resources and result in a more equitable system of
resource allocation across Ontario hospitals (Lave, Jacobs & Market, 1991). In first phase of the program, an equity fund of $25 million was established that was used to adjust the budget levels of hospitals who performed above or below the level of their peer group, in terms of costs, for the complexity of care provided. This equity fund was designed to make funding among hospitals fairer and to provide an incentive to control costs. In addition, the MOH modified the formula for growth funding to provide incentives for cost-effective care.

1.3 Relevance of the Study

Resource allocation decision-making in hospitals merits study for several reasons. First, as noted earlier, decisions by large organizations about how they allocate their resources have an impact on the economic and social life of society; in the case of hospitals, their decisions affect the kinds, the amounts and the quality of health care services that are available to the public. Second, although the hospital sector is a major one in terms of utilization of health care resources, few in-depth studies have been conducted to examine how hospitals actually make decisions about resource allocation. Third, although there are some models that seek to explain how resource allocation decisions in organizations are made, there is limited empirical evidence for the application of these models to hospital decision-making. Many of the conceptual models of hospital decision-making are prescriptive, rather than descriptive, and do not provide an understanding of the processes involved in making such decisions, the factors affecting
decision-making and the context within which decisions are made. Fourth, the necessity of making choices in resource allocation has increased in an era of economic restraint and the growth of expensive technology. Attention to how these factors affect decision-making and choice in hospitals can shed some light on approaches that facilitate or hamper the process and help identify important factors to consider in decision-making. A final reason why this topic merits investigation is the increased public debate about how health care resources should be spent and how such decisions should be made. This debate flourishes despite limited research on how decisions are currently made in Canadian hospitals. Economic restraint in the health care sector will bring with it more intense scrutiny of how resources are allocated and used and there will be growing demands for accountability with respect to decisions and decision-making processes.
CHAPTER 2

LITERATURE REVIEW ON RESOURCE ALLOCATION DECISION-MAKING

The initial broad research questions of who, how and why resource allocation decisions are made in hospitals guided the review of the literature. Theory and research that sheds light on the topic of resource allocation decision-making comes from a wide variety of disciplines, including economics, political science, the administrative or management sciences and moral philosophy. The literature on decision-making in organizations is extensive; that which focuses on resource allocation decision-making or on those kinds of decisions in hospitals in particular, is more limited. I drew on literature from a wide variety of sources and have organized the review to address decision-makers, decision processes and decision-making under fiscal stress.

2.1 Resource Allocation Decision-makers

Who are the key actors in resource allocation decision-making and what roles do they play? The attention given to decision-makers varies in models of organizational decision-making. A number of models assume a single actor or treat the organization as a unified actor and in these models, it is the goal of the actor that is important in decision-making. In the classical theory of the firm, there is an assumption that the decision-makers of a business firm have a goal of profit maximization and that resources will therefore be allocated in a way that most efficiently
optimizes that goal (Cohen & Cyert, 1975). This assumption of a unified actor is evident in Wittrup's (1975) model of social institutions as organizations that seek to maximize services as these bring power and prestige to the institution. Similarly, Lee (1971) bases his "conspicuous consumption theory of hospital behavior" on the assumption that a hospital administrator's utility is maximized by that which increases the prestige and status of the organization.

Some models explicitly describe a key decision-maker at the top of an organization. Weber (1946) describes a bureaucratic model of organization, characterized by a hierarchical chain of command, at the top of which is a decision-maker with rational-legal authority. Although more prescriptive than descriptive in approach than Weber, classical management theorists also focus on patterns of authority and they advocate the design of organizations in a way that ensures the efficient execution of duties and tasks as directed by those at the top of an organization (Morgan, 1989). The rational model of policy-making from political science also assumes a single actor who establishes a goal, examines options in meeting the goal and selects the best means to achieve it (Allison, 1971).

Models with one actor and one goal have been criticized as inadequate in describing or predicting the behaviour and decisions of organizations (Mintzberg, 1983). Not only are there multiple actors in organizations, there are multiple and often conflicting
goals. Cyert and March (1963) replaced the notion of a single, unfortified decision-maker at the top of an organization with the concept of the organization as a coalition of individuals with different preferences who bargained over goals, attended to them sequentially and generated budgets. This view is similar to that found in "public choice" models of policy making from political science. The public choice model emphasizes political factors in decision-making in that it focuses on various actors close to the decision and the interactions among these players (Trebilcock, Pritchard, Hartle & Dewees, 1982). The interests of the actors, their skill and power in bargaining and the results are key in understanding policy decisions. The applicability of political science theories of policy-making by legislatures to organizations has been challenged however, and Stevenson, Pearce and Porter (1985) note that there has been little empirical research on coalitions in organizations and a variety of meanings given to the term coalition.

Harris (1977) disputes the notion of a single decision maker in a hospital and describes a hospital as "two firms in one" (p. 467). He views the dual authority structure of physicians and administrators in hospitals as "two firms loosely connected by a complex set of nonmarket relations" (p. 472), suggesting a coalition model of decision-making. In this model, physicians are the demanders and hospital departments are the suppliers, so
work in decision-making.

Occupational groups, with these latter two groups being relatively
structured roles by physicians, administrators, and other
employees is especially by more or less permanent power
concentrative relationship that involves power relationships, the
"concentrative relationship" that involves power relationships, they describe a
therapeutic relationship of the "hospital" power relationship. In
physicians as the dominant group in hospital decision-making. In
a Johnson, 1973). In contrast, "young and Salaman (1983), view
interdisciplinary dominated by a "top administrators" (Chana, 1979), Schultz
identify the need to the needs of physicians to an extensive that became
the evolution of the hospital from a "doctors' workshop" organized
many attributes of the degree of concentration between these two groups to
many authors have discussed the fulfillment of "administrative" and
physicians' "administrative" and physicians' "administrative"
like Harries, some authors who discuss hospital decision-making
practiced, intrusive, consultant, consultant, consultant.

Capacity and physicians attempt to provide it for their area of
expansion (Harries, 1974). As the hospital administration attempts to limit access
even to do whatever is necessary for the patient's well-being (p.
affected by the "strong authority" that is very unusual and is controlled by
hospital medical care is very unusual. What tipped are needed in terms of the short run,
very established what inputs are needed in those domains. The hospital must
In contrast to the dual model, hospital decision-making is frequently described in terms of a triad, with roles for the administrators, the physicians and the board of trustees (Brooks, 1994; Carper & Litschert, 1963; Eakin, 1984; Provan, 1991). Of the three, the role of the board is discussed the least in the literature, with some authors suggesting that hospital boards essentially "rubber stamp" decisions, and that their approval of proposals shaped by administrators and physicians is "automatic" (Greer, 1984). The role of boards may be more significant in Canadian hospitals however, as Carper & Litschert note that boards may be more influential in nonprofit hospitals. Eakin (1984) studied the role of hospital boards in Quebec and describes the traditional "elite" hospital board and its power relative to that of administrators and physicians:

Organizational power in the hospital is shared by the hospital administrator, the medical staff, and the board of directors. Power is not, however, equally divided among these three groups. Administrators are constrained by their lack of organizational control over the physicians and by the ultimate legal authority of the board of directors. Physicians, on the other hand, find their clinical autonomy is challenged by budgetary and organizational restrictions, while board members feel their part-time, volunteer relationship to the hospital and their limited technical knowledge limit their role in hospital decision making. The distribution of power among these three groups has varied over time with changes in community need and medical technology and with changes in the professional status of administrators (p. 401).

As the above quote illustrates, descriptions of hospital decision-making often focus on physicians and boards as undifferentiated groups, rather than on positions and roles
occupied by individual members of these groups. In contrast, the Chief Executive Officer (CEO) or top administrator role is frequently the one studied or taken to represent "administration" (Brooks, 1994; Lemieux-Charles & Leatt, 1992; Provan, 1991). Other members of senior administration are somewhat anonymous in most discussions of hospital decision-making, although Nestman (1992) identifies the chief financial officer (CFO) as having a key role in the budgeting process of Canadian hospitals and Moore's (1991) study of CFOs in 25 U.S. hospitals indicated that some of these positions have considerable input into decision-making.

Mintzberg's (1983) analysis of power configurations in organizations, suggests that resource allocation decision-making in hospitals might be even more complex and dynamic than that suggested by dual models and triads. He categorizes hospitals as "meritocracies", a kind of organization that features reliance on expertise, complex technology and autonomous professionals who gain power because of their skill and knowledge. In his view, power in these organizations is distributed unevenly, as members have varying levels of the knowledge and skill that is critical to the organization. In meritocracies, the CEO cannot depend on positional power alone, as the authority system is a weak one; instead, the CEO's power depends on political skill and the ability to negotiate with groups that have conflicting goals. Thus power relationships are "fluid" and influence in decision-making in hospitals may shift over time.
Young and Saltman (1985) also suggest that over time, power may shift in hospital decision-making as other occupational groups, external changes in policy or a hospital's local environment may threaten the controlling role of physicians. However, in accordance with their model of a hospital power equilibrium, they propose that physicians will adjust their power strategies in response to such threats and resist changes in the prevailing power balance. Using this model, one would expect a dynamic tension between groups involved in decision-making, but little change in the dominance of the physician group.

Descriptions of the decision-making in many textbooks and articles on hospital financial management are normative in tone and provide only a very general picture of the relative roles of the three groups (Cleverley, 1985; Dorman, 1991; Gapenski, 1993; Mestman, 1992; Suver, Neumann & Bolo, 1992). Boards of trustees and CEOs are considered to have responsibility and major involvement in determining the mission and future directions of the hospital and in generating a financial plan that reflects these directions. Physicians are viewed as having considerable input into strategic directions and financial plans and are often the ones that generate proposals for new programs and equipment. While the physicians provide input and make requests, administrators generate the detailed plans in accordance with board guidelines and directions, while the board holds the ultimate authority to approve such plans.
Researchers have examined the participation and influence of the three groups in resource allocation decision-making, although many studies focus on only two of the three groups. Young and Saltman (1985) present two interview-based case studies in which they describe programmatic and budgetary decision-making in a community hospital and a teaching hospital in the United States. They interviewed chiefs of services, staff physicians, administrative personnel and staff nurses, but no mention is made of interviews of board members. Their analysis of these cases supports a hospital power equilibrium model of decision-making in which physicians control decision-making, eventually obtaining the programs and capital expenditures that they wish to obtain, despite delays and resistance from administrators. Although they examined other professional groups, particularly nursing, these groups were relatively powerless in the community hospital. In the teaching hospital, there was unresolved tension between physicians and nurses with respect to decision-making.

Most recent research has focused on allocation of capital budgets in hospitals. Citing the "duality of command and tradition" in hospitals, Kamath and Elmer (1989) investigated the involvement of medical staff in capital budgeting decisions through a survey, with responses from 120 not-for-profit U. S. hospitals of more than 200 beds. Eighty-eight percent of hospitals reported that medical staff was involved in various ways, from providing subjective input (87%) to making the final accept/reject decision
(14%). The researchers did not categorize types of capital decisions, the role of other groups or the extent to which physician input and involvement influenced final decisions made by others.

Deber, Wiktorowicz, Leatt and Champagno (1994) conducted a national survey in 1990 to examine technology acquisition by Canadian hospitals. Technology was defined as capital equipment in this study and data were obtained, through a survey, from 564 hospitals. The researchers found that overall, hospital committees involving medical and nursing staff made decisions, administrators shared authority for decisions and that the board of trustees primarily ratified decisions, although in some hospitals, boards had a stronger role. Although hospitals in the study used committees with varying compositions and mandates, of the 496 hospitals that reported using committees, the groups with major representation on the decision-making ones were the administrative team (41.3%), the board (32.3%) and medical staff (10.2%). These results suggest that although input may be obtained from a variety of personnel at a number of hierarchical levels, members of senior administration, the board and the medical staff can heavily influence final decisions. The analysis did not include decisions about large, capital projects involving buildings and land and committee composition was not analyzed in terms of type of equipment (new or replacement, minor or major).

Some researchers have found that the relative role and
In the strategic-transactional decision system, technologies that reflect changes in the healthcare market and customer needs are critical. Hospitals and health systems are under pressure to improve efficiency and reduce costs. The use of evidence-based practices, such as randomization, is essential to ensure the effectiveness of interventions. Hospitals and health systems may use data analytics to identify areas for improvement and to evaluate the impact of new technologies. The adoption of such technologies is not only driven by patient outcomes but also by the need to stay competitive in the healthcare market. This requires a strategic approach that considers the alignment of technology with the organizational culture and objectives. The successful implementation of technology requires careful planning and execution, including training and support for staff. The benefits of technology adoption can be significant, including improved patient outcomes and increased efficiency. However, the challenges of integration and resistance to change must be addressed to ensure successful implementation.
hospital's mission and directions, decision-making was dominated by the board of trustees and the CEOs. Although physicians, particularly referral physicians outside of the hospital, might play key roles, physicians from the medical staff generally did not dominate this system and they may even be resistant to such large-scale organizational change. Based on her analysis of technology decisions, Greer highlights the limitations of professional dominance theory in explaining technology adoption at the level of the hospital.

As part of the same study as Greer's, Meyer (1984) examined 300 budgetary decisions from the 25 hospitals. He describes four decision models to which medical equipment proposals might be subjected: the clinical model, the fiscal model, the political model and the strategic model. Using a clinical decision-making model, physicians may evaluate equipment in terms of benefits for individual patients, although the stature of the requester may also be influential in the decision. Using the fiscal model, administrators may apply computational techniques to assess the financial merits of an equipment proposal. In the political model, coalitional bargaining among physicians, administrators and board members might determine the fate of capital equipment proposals. Board members and chief executives are influential in shaping strategic directions for a hospital and using the strategic model, decisions are made, particularly about long-term capital commitments, that fit with strategies designed to position the
hospital in terms of competition and trends.

Provan (1991) examined the relative influence of hospital CEO's, boards and medical staff in management decisions using data from national surveys of US hospitals. Data from 287 non-profit community hospitals were included in the analysis. Provan was interested in the amount of internal hospital management information received by those groups and the relationship between receipt of information and influence in decisions. He found that CEOs received "by far" the most information, followed by the board and then the medical staffs. The total amount of influence for four generic decisions was highest for the CEO, followed by the board and then the medical staff. Across the three groups, there was a positive relationship between receipt of information and influence over decisions. Within groups however, the relationship was strong for medical staff, moderate for boards and non-significant for the CEO. Provan interprets this finding as an indication that only large decreases in information received by the CEO would cause a change in the CEOs influence, given that the CEO normally receives most information anyway, but that receipt of information is more important for the other two groups.

It seems likely that the CEO is in a position to exercise some control over the distribution of management information to other groups, and this possibility raises questions about nature of the relationship between CEOs and boards and CEOs and physicians. Case studies from Canadian hospitals suggest that these relationships
Although models of hospital decision-making suggest that the board, administration, and medical staff all play key roles in resource allocation decisions, those interviewed in the offices of board, administration, and medical staff all noted that the existing decision-making structures did not support the incorporation of data from all of these groups. Nevertheless, they viewed the role of the organization with key senior physicians and other key decision-makers as essential to the effective functioning of the organization. They also noted that they were sometimes asked to make decisions that were not aligned with the goals and priorities of the organization. These decisions often involved balancing the needs of different stakeholders and prioritizing resources based on various factors.

Bradshaw-Campbell (1986) identified a number of factors that contribute to the effective functioning of hospital boards, including a strong sense of community, a commitment to the well-being of patients, and a willingness to engage in constructive dialogue. Other studies have suggested that effective board leadership is characterized by a focus on strategic planning and long-term vision, as well as a willingness to delegate responsibilities and empower staff. In general, the role of the board is seen as critical to the success of any hospital.

While there are a number of challenges facing hospital boards, there are also a number of strategies that can be employed to address these challenges. These strategies include providing ongoing education and training for board members, developing strong relationships with key stakeholders, and fostering a culture of transparency and accountability. By doing so, hospital boards can make the best possible decisions for their communities, and help to ensure the long-term success of their organizations.
decisions by hospitals as government resources became more scarce and new questions were raised about responsibilities within institutions (Barkin, 1991; Darr, 1991; Veatch, 1991b). Some authors believed that there had been a shift in power from physicians to administrators, making responsibilities less clear (Hiller, 1984; McNerney, 1985), but other authors began to argue that medical ethics ought not to determine resource allocation in health care, but rather social ethics as judged by society or its representatives (Mooney & McGuire, 1988).

The growth of health care costs and subsequent government funding restraint raised public policy questions about macroallocation by politicians and about distributive justice in decisions based solely on economic evaluations. Drummond, Stoddart and Torrance (1987) note that such a policy concern is justified, as "economic evaluations do not usually incorporate the importance of the distribution of costs and consequences into the analysis" (p. 33). Hiller (1984) acknowledged the growing public policy debates about distributive justice, but argued that hospitals must make allocation decisions in the absence of resolution of such debates. According to Darr (1991) both governments and health services organizations make macroallocation decisions and involve managers and clinicians in doing so.

In the late 1980's, the state of Oregon in the United States tackled the question of how resource allocation decisions about health care ought to be made in society, given insufficient
resources to meet all needs and demands. Oregon embarked on a project to examine what the public valued with respect to health services and what benefits could be expected of various services based on scientific information and professional consensus. Using a "blend of public values and facts" (Sipes-Metzler, 1994, p. 305), decisions were made about priorities for publicly-funded health services. This experiment generated much discussion, but most of it focused on the role of experts and the public, rather than the role of public institutions (Caufield, 1993; Dougherty, 1991; Madorn, ; Veatch, 1991b). Some proposals did emerge however, on how hospitals could engage in ethical resource allocation decision-making. Veatch (1991a) believes that administrators in public hospitals should "view themselves as agents of the society, accountable to the people as a whole" (p. 23). He proposes that the public ought to decide on broad principles that form the basis for allocation of health resources, and that administrators could then be charged with the responsibility for translating those principles into decisions. In his view, hospitals could establish a patient advisory group to set limits to spending, based on criteria established by specific patient populations. Health care professionals, in nonclinical roles, could provide technical advice to the patient advisory group. In clinical roles however, professionals must focus on individual clients, not on society as a whole.

Less has been written about the ethical aspects of resource
allocation decision-making in hospitals within the Canadian system of health care, but a provincial Deputy Minister of Health expressed the view that boards had moral responsibilities with regard to such decisions (Barkin, 1991). Barkin refers to hospital resource allocation decisions as ones of "medium level ethics of health care" and believes that Boards must respond to the greater public interest in making allocation decisions. He implies that hospitals could be making better decisions and challenging hospitals to use the knowledge and information available to improve the management of health care. He cites examples from Canadian hospitals in which the use of information both improved patient care and reduced expenditures.

The extent to which hospital policy makers actually experience ethical problems in resource allocation decision-making has received limited attention, although there is some evidence from Canadian studies that such problems arise with economic restraint. In one study (Chown, 1990), Canadian health care executives reported that resource allocation decisions were among the most frequent and difficult problems they encountered. In an open-ended question, respondents were asked to briefly describe their most difficult ethical problem in the past two years. The third most frequently mentioned problem was that of allocation of resources, reported by 3% of those answering the question. When asked about ethical problems faced most frequently in the past two years, the
references in the work-related communications by managers, despite the term moral misconduct to describe the occurrence of moral
discussed, nor is such discussion encouraged, in these types of
discussions, however, that ethical issues are generally not
discussed. There is some evidence from studies of managers in business
to those at higher levels, who are more distant from patient care.
management and to the "anger" of middle managers. It is felt by
educational issues are actually raised and discussed during hospital
studies. Yet, ethical issues are no indication of the concern or to what
asked about the ethical aspects of resource allocation in the
Although middle and senior managers raised ethical issues when
plan to directly prioritize for care.
that care and the potential of using the hospital's scarce
health care roles. The role of managers in should be making societal decisions, their roles as gatekeepers
are the managers raised questions about who
resource allocation and utilization and "managers around decisions in
how resource prioritization and managerial responsibility conflict between
these managers experienced considerable ethical conflict between
hospital and a decentralized management system. They found that
a percent (1997) examined ethical issues for医护人员-managers in a
using focus groups, letterboxes, charts, messages, and, Baker &
resources, mentioned by 27% of those responding to the question.
second most frequently mentioned problem was allocation of
their private acknowledgment that moral standards affect their decisions and observations that their actions are consistent with such standards.

2.2 Resource Allocation Decision Processes

How are resource allocation decisions made in organizations? A variety of decision-making processes and perspectives on such processes are discussed in the literature and these are categorized here as bureaucratic, techno-rational, and political processes.

2.2.1 Bureaucratic Processes

The bureaucratic perspective on decision-making is evident in those who examine or advocate processes in terms of legal authority, levels of responsibility, the chain of command, the division of labour and the roles and expertise of various office-holders in the organization. The description of hospital decision-making in these terms can be found in many text books and articles, suggesting that there is much about hospital decision-making that fits a bureaucratic model. Nestman (1992) describes the budget plan of a hospital as emanating from the operational plan which, in turn, is derived from the mission, goals and objectives of the organization, all of which must be approved by the board of trustees who hold legal authority:

The governing board's approval and commitment is critical, and when financial commitments are made they are usually through the finance committee in consultation with the chief financial officer and senior administration. With the mission statement, goals and objectives being the pillars of the process, the finance committee and senior administration
choose levels of decision-making. Operating decisions are described
more than one year. Gordon, Mittler, & Minzerberg (1975) described
that capital expenditures are for items that provide service for
decisions concerning expenditures for long-term assets; nothing
decisions. Capital budgeting is the process by which items make
an operating budget. Gordon and Flanche (1984, p. 1)
resource allocation decision-making with respect to capital
authorization.

simrall, in terms of responsibilities, roles and levels of
Similarly, presents a description of the budgeting process that is
by the finance committee for recommendations to the board. Gordon
by various levels of administration and then reviewed and approved
an operating budget for the organization. Supervisors are consolidated into
departmental budget supervision. Supervisors are consolidated into
in the organizational goals and objectives. In the
shorter role as supervisors to that of departmental managers, who often
management of health service organizations" (p. 24) and describe
management of health service organizations have "shown an increasing interest in the
of the medical staff have "shown an increasing interest in the
physician, such as the chief of staff. Neshman notes that members
composed of the CEO and other administrators as well as a smaller
organization, often via an influential budget committee
once the quick decisions are set, these are transmitted to lower levels
budget year (p. 21-22).

desired operating and financial results for the forthcoming
establishment program and financial guidelines which describe the
by lower level managers, are short-term and involve relatively small resource commitments. Strategic decisions are long-term, non-routine, require major resource commitments and involve senior hierarchical levels in decision-making. Administrative decisions are mid-way between the two.

In the literature, use of the term capital budget is variable however, in that some authors are referring to large-scale investment in machinery, buildings and land (Bower, 1970), technology acquisition by a hospital (Deber et al., 1994, 1995) medical technology only (Greer, 1964), a hospital's capital equipment budget with a pro-sct limit that excludes large-scale projects and expensive, high technology (Dorman, 1991), or a combination of all of those (Nestman, 1992). Therefore, some studies of capital budgeting may include decisions that range from purchase of a personal computer to purchase of a building. As a number of studies address all types of capital decisions, without exploring differences between categories, it is difficult to determine if bureaucratic processes predominate in decision-making for different types of capital expenditures.

Some use of bureaucratic processes in capital resource allocation decision-making is evident in descriptions, case reports, survey research and studies based on interviews with hospital personnel. Nestman's (1992) normative description of capital budgeting suggests that hospitals employ different levels
of review based on the cost of a capital item, with more intense and higher levels of review for higher cost expenditure, much as that described by Gordon and Pinches (1984). Deber et al.'s (1994) study of technology acquisition suggests that senior levels dominate committees that actually make and approve of decisions.

Standing operating procedures with respect to capital equipment decisions, consistent with notions of bureaucratic processes, were also evident in a number of studies. Rocher (1990) reports that in the course of a research project on the rules used by Quebec hospitals to decide on the acquisition of costly equipment, he interviewed a large number of physicians, nurses, administrators and biomedical engineers. He identified the use of three types of rules: constitutional, procedural and substantive. Constitutional rules were those that created a hospital committee to deal with acquisition, established the power of the committee, its composition and selection of members. Procedural rules were those related to the functioning of the committee such as who acts as chairperson and calls meetings and voting rules. Substantive rules are those that relate to the preparation of proposals and the kinds of information that ought to be provided to justify requests.

In contrast, Deber et al. (1994) found less evidence that decision processes for capital equipment had been bureaucratized. In their national study, only a minority of hospitals used standard forms for requests, suggesting that processes for capital expenditure decisions are not generally bureaucratized in Canadian
hospitals. Young and Saltman (1985) reported differing capital budget processes for the two hospitals in their study. In the community hospital, there was no formal capital budget each year and compiled capital requests were approved in an ad hoc fashion after the start of the fiscal year. In the teaching hospital, an annual process similar to, but separate from, the operating budget process, was used to consider capital requests and set priorities for the pre-set limit for capital equipment expenditures. Young and Saltman mention that the capital projects budget was developed separately, but that process is not described. Weingart's (1993) study of technology acquisition at 12 major U.S. medical centres, indicated that decisions were "ad hoc" rather than the result of "any regular, orderly, scheduled deliberative process" (p. 532).

2.2.2 Techno-rational Processes

Models that present decision-making as a rational cognitive process of goal setting, exploration of alternative means of meeting the chosen goal and selection of the best alternative have been criticized for failing to accurately describe the reality of decision-making processes in organizational life. One criticism is that such models ignore the cognitive limits of decision-makers; a second criticism is that there are costs to an organization in fully exploring all of the options to achieve an optimal solution. Subsequent theories described the "bounded rationality" of decision-making that "incorporate constraints on the information-
processing capacities of the actor" (Simon, 1966, p. 162). The idea that decision-makers "satisficed" and limited their search for solutions until they found a satisfactory, rather than an optimal one, also gained prominence. Despite the limits of human rationality in making decisions, such as resource allocation ones, rational management theories still view organizations and the individuals in them as "intendedly rational" (Hill & Mahoney, 1978).

An organization can enhance rationality in decision-making, despite the limits to individual rationality, by distinguishing between "programmed and non-programmed" decisions and using more technical processes for non-routine decisions (Delbecq, 1973). Using this perspective, the incremental method is inherently rational for organizations, in that established programs and the base budgets are not scrutinized annually and bureaucratic processes with established rules are used to make routine budget decisions about allocations.

The foremost theorist with regard to budgeting, the late Aaron Wildavsky, focused most of his research on government budgetary processes, although he found that "patterns of behaviour appear to be remarkably consistent across private and public organizations" (Wildavsky, 1968, p. 198). He observes that because of the complexity of budgeting in large organizations, participants simplify by "adopting aids to calculation": 
By far the most important aid to calculation is the incremental method. Budgets are almost never actively reviewed as a whole in the sense of considering at once the value of all existing programs as compared with all possible alternatives. Instead, this year's budget is based on last year's budget, with special attention given to a narrow range of increases or decreases. The greatest part of any budget is a product of previous decisions (p. 193).

Base budgeting then, is believed to constitute the core of the budgeting or allocation process, with most departments in an organization submitting budget requests that reflect their expectations that the base is established and that they will receive their "fair share" of increases and decreases (Wildavsky, 1986, p. 11). This kind of base budgeting is evident in Young and Saltman's (1985) case study of a community hospital, in which department heads submitted operating budgets, a vice-president returned these with instructions to cut by five per cent, and final decisions were made by the senior management team. In their case study of a teaching hospital, Young and Saltman report that senior administrators set the constraints for budget submissions from departments, submitted budgets were then reviewed and revised at several administrative levels and final decisions were made by the executive vice-president and president.

Only changes in proportional allocations or investment in new programs are subject to more intense scrutiny. This scrutiny may take many forms. In broad terms, such scrutiny involves formal analysis, an approach that Langley-Laporte (1986) defines as the "systematic study of issues". Much of the rational management
literature addresses the development of sophisticated decision techniques, such as simulation, linear and dynamic programming, as a means of making better decisions, but formal analysis can also encompass qualitative methods and less sophisticated quantitative techniques (Lockett, 1976; Campbell, 1987; Langley-Laporte, 1986; Simon, 1966).

A considerable body of literature has been generated by authors who address techniques to enhance resource allocation decision-making in health care. Economic evaluation of health care programs is advocated to make the best use of health care dollars available. Cost-effectiveness analysis (CEA) is aimed at estimating the "efficiency with which health care technologies use limited resources to produce health outputs" (Weinstein, 1990, p. 93). The C/E ratio can be used by decision makers to compare investments in competing health care programs with one that currently exists or with the absence of a program if none exists. Drummond, Stoddart & Torrance (1987) point out that CEA should follow trials of the clinical effectiveness of a new technology.

Williams (1985) set out the problem of resource allocation decision-making in a discussion of the economics of coronary artery bypass grafting. He identified bypass grafting as one contender for additional funding and argued that under ideal conditions, "all such contenders should be compared each time a decision on allocation of resources is made to test which should be cut back and which should be expanded" (p. 326). In an attempt to improve
Wrighting in the context of health care in the United States, alternative and external costs to society, and operating costs, terminal cost of societal life, opportunity cost of hospital's usual performance in-depth financial analyses and notes assessment. Neustadt (1981) writes that financial personnel in formal analyses advocates are financial analysts and accountants. The two kinds of expenditures and new directions for a hospital. The two kinds of budgeting, perhaps because these decisions often involve larger health care. Much of the research on the use of analyses in decision-making (Appraisal, Reay, & Trumble, 1990; Caflin & Burch, 1993) studies in the real world of resource allocation dectects and the interpretation of measuring health outcomes. (1996) and the interpretation of judgments, Basmajian & Got, 1993). Methodological problems in these techniques are still debated in terms of ethical, scientific, and political increase decrease or maintenance levels of bypass grafting. Many of the resources before decisions were made on whether or not to increase, decrease or maintain levels of bypass grafting. Ideally, comparisons would be made with other potential ways of treatment. Comparisons would be made with other potential ways of treatment. Comparisons would include those required for diagnostics and treatment costs would include those required for diagnostics and treatment.

For the quantity of life, for "quantity adjusted life year" (QALY's), a procedure would be measured based on "life expectancy adjusted for the quantity of life," he proposed that the benefits of traditional reliance on more survival rate, without
locating future projects in hospitals with studies of other industries and of
inventories, but in comparing their findings on use of

only 27% of the hospitals used financial techniques for all of their
while the remainder used only one to evaluate projects, but
 Fifty-seven percent (57%) of the hospitals used one technique
Return (10%), Profitability Index (PI), and Net Present Value
of projects was payback period (65%), followed by Internal Rate of
that the mean weighted need capital budgeting techniques in evaluation
favored and that the mean weighted need capital budgeting techniques in evaluation
Eimer's 1986 study of hospital capital budgeting practices showed
in hospitals, decision-making processes is limited, narrow, and
evidence that the extent to which such techniques are actually used
programs (Alda et al., 1994), there is some
marking about the adoption of new health care technologies and
Although many authors argue for formal analyses in decision-

processes.

With a firm's strategic directions and resource allocation
on technical questions and data, we can consider how the techniques
 hate, but caution that there is a danger in focusing too narrowly
Sophisticated capital budgeting techniques have been adopted by
the product's life cycle, Phases (1990) notes that over time,
project's cost in terms of risk and debt capacity and assessment of
assessment of the risk of the estimated cash flows, estimation of the
capital outlook, forecasting of operating cash flows of the project,
analyses of capital investment proposals; estimation of the
identifiers. These steps to be followed in conducting a financial

33
incorporating technology assessment into the process. They note that expenditure by improving the capital budgeting process, that sought to deal with increasing demands for capital funds, presents a 1991 case study of an Ontario teaching hospital for resource allocation decision-making. Maritz, Fleming A. (1991) In may be that hospitals deal with nonprogrammed, more complex decision-making. Although such decisions are no longer adequate" (p. 26).

Similarly, Dober et al. (1994) found that independent sources of information on technology assessment were rarely obtained by health-care centres. Study of technology acquisition at 12 V. S. hospitals and 42% evaluated about half or less.

prevalent at all investment proposals, 10 of evaluated less than 10 of authors found that about 25% of hospitals used techniques to employ the sophisticated quantitatively techniques" (p. 57). The hospitals, they have a lot of catching up to do when it comes to technology. It seems to have been some increase in the use of techniques by hospitals in earlier surveys, the authors note that while there

4
advocates for technology acquisition, they recognize that some institutions may have particular goals that influence their
strategy. In the same vein, Lumpkin et al. (1992) note that although they
scarcity with many "dimensions, beliefs and values" (p. 461-462),
an "incorporation process" that must incorporate the "crucial" of
as a bridge between science and policy and through policy-making as
allocation decisions, backtesting (1992) sees technology assessment
alternative and technical ones must be considered. In resource
management and in management of resources, one must consider the
cost of and alternative means to meet commitments or other than
contact services.

An internal plan was also considered as the emphasis of certain
criteria were developed to guide decision processes and the
then fed into the subcommittee's capital budgeting processes.
then, the subcommittee hired a consultant firm to assess the current
diagnostic imaging equipment that cost more than $100,000. The
three administrators was set up to develop a five-year plan for
general capital requests. A sub-committee of six physicians and
million for high-tech categories and the remaining $2.5 million to
committee decided to deal with these separately: appropriations to
department for 34 million in high-tech equipment, the
about some capital requests. Following repeated requests from the
experiences was not available on the committee to make decisions
"high-tech" high cost equipment and there was concern that
that the usual budget process created a bias towards technical and
resource allocation decisions independently of cost-effectiveness considerations" (p. 479). They give the example of a tertiary level hospital that will naturally want to adopt bone marrow transplantation technology rather than an immunization program. Gapenski believes that factors other than economic ones must be taken into account in capital decisions, such as "the needs of the medical staff and the good of the community" (p. 416). He notes that in not-for-profit organizations, the goal is "cost-effective service to the communities" and that capital budget decisions do not rest solely on profitability (p. 415-416).

Although several authors acknowledge that quantitative and qualitative analyses are required for some decisions, the nature of qualitative analyses is less clear and is less trusted. Nestman argues for clarity about the criteria used in setting priorities for capital decision-making as he believes these "will provide a more objective process for decision-making while cutting down the 'politics'" (p.134). Suver, Neumann and Boles (1992) believe that an economic analysis should be conducted to assist in the valuation of capital projects, but acknowledge that "political and nonquantifiable aspects of the project may overwhelm the economic aspects" (p. 117).

Some researchers have examined the influence of "qualitative" or "nonquantifiable" factors in hospital decision-making. Kamath and Elmer (1989) found that only two of 120 hospitals indicated that "qualitative" factors did not enter into capital investment
decisions. When presented with nine factors, respondents ranked these qualitative factors in descending order of importance: facility need, physician demand, community need, enhance marketability, attract professional staff, government regulation, positive image, employee morale, employee safety. One quarter of respondents reported that such factors determine an accept/reject decision more than 76% of the time. Thirty percent of respondents said that these factors determine the decision 51 to 75% of the time. The authors seem to believe that a move to more "objective" evaluation is required:

While qualitative factors continue to play a major role, the present survey indicates a positive trend toward less complete reliance on qualitative factors leading to subjective evaluation (Kamath & Elmer, 1989, p. 34).

Deber, Wiktorowicz, Leatt & Champagne (1995) received 989 questionnaires from decision-makers at 238 Anglophone hospitals in Canada in which they reported on their perceptions of the importance of technology assessment and a number of other factors in technology decisions. Respondents clearly accepted the importance of technology assessment, but it was intermediate in importance in a list of 25 variables. The top three important factors in decision-making, in descending order, were quality of health care, need and compatibility with the institution's role and mission. Factors such as desire to please medical staff, sense of equity and prestige of an item or a requesting unit ranked low on the list of variables.
2.2.3 Power and Political Processes

Many who criticize classical management theory and rational management theory do so because they view power and politics as key in explaining organizational decision-making. Power is the ability or capacity to bring about outcomes and one form of power is that which is inherent in an official position that carries formal authority. This kind of power is used in the organization as part of what Mintzberg (1983) calls the "system of authority," but he identifies other systems of influence that operate in organizations as those of ideology, of politics and of expertise. Mintzberg (1989) views politics in organizations as essentially illegitimate and compares it to an illness--dangerous to healthy functioning, yet having value in that it alerts the organization to the need to adapt. He believes that at one level, politics can operate as one force in an organization without dominating it. However, politics can emerge as a dominant force and affect legitimate power. Some other authors take a similar view and distinguish politics as behaviour that is unsanctioned in terms of organizational goals, formal authority or accepted policies and procedures (Cavanagh, Moberg & Velasquez, 1981; Alexander & Morlock, 1994).

Pfeffer (1992) notes that there is a great deal of ambivalence about power in organizations and believes that although there is acknowledgement that politics exist in organizations, there is a perception that it interferes with efficiency. He argues that
power in organizations is a reality and that power and influence should be seen "as one of a set of ways of getting things done--not the only way, but an important way" (p. 28). Unlike Mintzberg, Pfeffer and other authors do not explicitly characterize organizational politics as illegitimate; rather they seem to treat the use of all forms of power as political activity, as organizational decision-making involves coalitions, differing preferences, negotiation and conflict (Bacharach & Lawler, 1962; Burns, 1961; Tushman, 1977; Morgan, 1986; Wildavsky, 1986; Zalenzik, 1976).

Resource allocation decision-making is seen by many as inherently political. According to Wildavsky (1962, p. 192), budgets are "attempts to allocate financial resources through political processes". He wrote:

If organizations are seen as political coalitions, budgets are mechanisms through which subunits bargain over conflicting goals, make side-payments, and try to motivate one another to accomplish their objectives (Wildavsky, 1986, p. 6).

Pfeffer (1977, p. 201), describes a model of organizational resource allocation as "one in which power and influence operate to affect decision outcomes". He views the use of power and influence as "inevitable in organizational decision-making", in the absence of shared goals and choice criteria. Pfeffer proposes that while dissensus is one condition for the use of influence in decision-making, another dimension to be considered is that of the amount of control by hierarchical authorities. Using these two dimensions,
a two-by-two matrix is presented that yields four models of organizational decision-making: professional model, bureaucratic model, political/coalition model and centralized model.

Pfeffer proposes that when there is high consensus about goals and preferences and technology, but little control by authorities, the organization has a professional model of decision-making. He suggests that there is self-control by professionals and shared norms that permit collegial decision-making to be effective. When there is this kind of consensus, as well as high control by authorities, the model of decision-making is bureaucratic. With dissensus and no central authority, the political or coalition form of decision-making is likely. When there is dissensus and high control by authorities, the decision-making model is a centralized one. Pfeffer explains that power is more likely to be used under conditions of uncertainty (and dissensus), as there is no recourse to objective standards for decision-making. Although he does not discuss hospitals in particular, many would argue that there is considerable dissensus on goals and technology in hospitals (Perrow, 1963; Mintzberg, 1983), suggesting that hospitals would be characterized by either a political or centralized model of decision-making, depending on the degree of control held by organizational authorities.

Pfeffer believes that because rationality is so valued by society, "the use of power must be relatively unobtrusive" (p. 241). He describes mechanisms whereby those who wish to influence
decisions do so somewhat covertly: by promoting the selective use of legitimate criteria (those that favour one's position), by using decision procedures that are perceived as legitimate, such as the use of committees that can be co-opted or influenced, by centralizing through majority rule, and by controlling information in the organization through withholding information or secrecy.

Mintzberg (1983) describes how politics are played in organizations by describing a set of "political games" that take place in what he calls the "internal coalition", that part of the organizational configuration made up of the top managers, the operators or producers (such as doctors and nurses in a hospital), the staff specialists and the support staff (p. 29). He describes thirteen political games that form part of the "system of politics" that operates in organizations. He notes that resource allocation "is a natural focus of conflict in the Professional Bureaucracy" for a number of reasons:

First, the federated nature of the structure means that the professionals, and often their units as well, work rather independently of each other. All they need do is share common resources--funds, facilities, and support staff...So the allocation of resources emerges as a central source of conflict, especially when resources are scarce. If the outputs or performance of the professionals could easily be measured, an objective basis for resource allocation could be found--one tied to organizational needs. But they cannot, and so the basis of allocation can easily become political, allowing considerable opportunity for empire building (p. 402).

Although there are many types of games, political activity in meritocracies "revolves first and foremost around the processes of
resource allocation and pigeonholing, and second around the selection of strategic candidates" (p. 402).

Harris's (1977) "two firms in one" model portrays the hospital as rife with conflict as the hospital administration attempts to limit excess capacity and physicians attempt to protect it for their area:

Like many other organizations, therefore, the hospital must solve this capacity problem with a rather wide variety of nonprice-related decision rules. There are loosely enforced standards, rules of thumb, side bargains, cajoling, negotiations, special contingency plans, and in some cases literally shouting and screaming. As the hospital approaches short-run full capacity utilization, these allocative devices become increasingly important (p. 478).

Harris believes that both sides attempt to defend their position with regard to capacity, but both lead towards a larger and more complex hospital. Young and Saltman's (1985) model of the hospital power equilibrium is similar in terms of process and outcome. The case studies describe how physicians obtain new personnel or equipment by "end runs" to the chief administrator or the board of trustees and "foot-in-the-door" strategies to introduce new programs.

A number of researchers have examined theories of intraorganizational power and focus not on individuals and political behaviour, but on the power of subunits and the impact of that power on the internal allocation of resources in an organization. Although no study of intraorganizational power was found using data from a hospital, universities are considered by
some to be similar to hospitals in that as professional bureaucracies, professionals work rather independently in a federated type of structure (Mintzberg, 1979). Studies in these types of institutions have provided some evidence that "bureaucratic universalistic criteria" have an impact on allocations, but that subunit power also is a factor in that for more powerful departments, changes in budget allocations over time were less affected by changes in workload over time (Pfeffer & Salancik, 1974). Subunit power was based on the ability of the subunit to bring in critical and scarce resources, such as grants and contracts, national prestige and graduate students. In Hackman's (1965) study of six institutions of higher education, a unit's environmental power, institutional power and resource negotiation strategies explained approximately half of the variance in resource allocation and a unit's institutional power separately influenced its resource allocation.

Hickson, Hinings, Lee, Schneck, and Pennings (1971) describe a strategic contingencies' theory of intraorganizational power that focuses on subunit power with respect to internal and external factors. In this conception, power is explained as a function of three key variables: the ability of a subunit to cope with uncertainty, the centrality of the subunit in terms of workflow and the substitutability of activities of the subunit. The more that a subunit can control contingencies for the activities of other subunits, the more powerful that subunit in that dependencies are
created. Hinings, Hickson, Pennings and Schneck (1974) tested this theory using data collected from four subunits in seven industrial firms. They found some support for the theory in that 24 of 28 subunit power rankings were explained. In profiling the rankings, all of the variables seemed necessary for a subunit to achieve top ranking. Coping with uncertainty was the most important variable and nonsubstitutability contributed to top-ranking, while immediacy of workflow contributed to second-ranking of subunit power. Pervasiveness, while required for top ranking, was insufficient on its own to rank a subunit very highly in an organization. As the structure, workflow and the nature of the work in hospitals differs from that of business firms, these findings might not hold for hospitals.

A number of studies of the process of allocating capital funds in an organization suggest that there are political aspects to the process, especially for that portion of the capital budget devoted to large cost items and major investments that may flow from strategic decisions (Gordon & Pinchos, 1994). Bower (1970) developed a process model of capital budgeting in an in-depth study of the "investment process" in a national business firm. Bower notes that it is not just a "mechanistic problem-solving" process that explains how capital resources are allocated (p. 67). He describes a definition phase, in which a manager responds to information about a problem or opportunity and initiates technical and economic studies. Planning takes place that addresses
corporate concerns about the larger environment and finance. In the definition process, the project moves beyond a technical and economic focus to a funding proposal that must compete with others at higher levels for support. The impetus process explains how projects move towards funding within an organization and this process requires the willingness of someone higher in the hierarchy to commit to the project and to sponsor it at higher levels. Such commitment is affected by the more senior manager's evaluation of the advantages and disadvantages to him in sponsoring such a project and whether or not it will increase confidence in his judgement and skill. The final phase of the impetus process occurs when there is approval at the corporate level. Context refers to forces in the organization that affect the definition and impetus processes including, corporate structure (such as formal organization and information systems) and situational context (such as personal and historical factors).

Meyer's (1984) study of capital budget decisions from 25 hospitals led to the identification of four decision models, mentioned earlier, one of which was a political model. He found that proposals "travel" through a hospital and undergo assessment based on more than one model. When the assessments from these analyses generate different decisions, negotiations result that generate tensions. The tensions are somewhat mitigated by the use of "ceremonial acts"--the symbolic mode of decision models.

Meyer describes a "pliant utility model" applicable to the
higher levels of the organization, a factor identified in power’s never does not specify that sponsors in hospitals must come from consistent with power’s theory of capital budgeting’s but prioritization thresholds converge. The notion of a sponsor is sponsors apply pressure and the upper and lower boundaries of the sponsors from the middle category to the higher or lower categories as from the middle category to the higher or lower categories as in the third, step function phase, proposals may be shielded budget.

not be further evaluated, but they are almost never added to a program, although they are almost never added to a program, and continue to cycle in the incremental mode without the symmetric situation. As proposals are not, is almost, enough agreement to be achieved to make a decision. A decision, proposals, are not, is almost, enough agreement to be achieved to make a decision.

participation to assessment evaluations and decision proposals as used in incremental evaluations, some room is available for and desirable. As these categories are not, is almost, enough agreement regarding proposals in terms of prioritization, using a system of evaluations are examined in terms of prioritization, using a system of utility phase, proposals move to a form in which those underpinning and language, but insulated from one another. In the segmented all the modes as it revealed, each model using different criteria resulting from this model. The proposals may undergo internal evaluations using criteria, the model of a medical capital budget, the monotonous utility development of a medical capital budget.
study of a business firm. The "ceremonial" aspect of decision-making may continue and in Meyer's (1985) view, this aspect assists in mending organizational rifts and fostering commitment.

Rochor (1990), based on his study of capital equipment decision-making, also found that there is more to decision-making in an organization than a budget outcome. He identified three "special" rules of procedure that were less visible than the formal bureaucratic rules: the rule of participation, the rule of consensus and the rule of "chacun son tour" (p. 225). The rule of participation is based on the idea of democracy and is intended to provide all physicians in the hospital with the opportunity to identify requests and agree within their departments on requests. The rule of consensus is evident when the hospital administrator tells physicians to come to an agreement, so that their agreed-upon requests can be forwarded to the Board. The rule of chacun son tour is designed to ensure "medical peace" in the hospital in that there will be a recognition that everyone "gets a turn" in acquiring equipment and that this rule will be considered in negotiations.

Rochor (1990) views all of these rules as having manifest and latent functions in hospitals. The visible functions relate to an awareness of limited resources, a certain orderliness in functioning and the avoidance of great injustices. The less visible, or latent, functions are, in Rochor's view, more
are part and parcel of hospital decision-making. Allocation decision-making, each indicate that potential processes are part of the process of decision-making with Quebec's changes in board process of decision-making with Quebec's changes in the board. Recently, consultation, information sharing and procedural changes in the Quebec hospitals and-senior physicians over strategic directions in a Quebec hospital. Lafortune (1990) describes various bargaining between the CEO and senior administrators. From the Ministry of Health, Lafortune states that Quebec's decision process is an absolute hospital. In order to an intervention of financing criteria in an absolute hospital, Quebec's decision process is part, particularly when decision-making is made about a number of different topics, indicating that decision-making is a case study of Canadian hospitals, conducted to examine a justice.

Justice, that procedural justice does not necessarily result in distrust, is the sense of due process (p. 227). Proctor notes that procedural justice refers to the rules are followed and the process is consistent with the hospital's rules, to which the rules create the view function to establish a reality of limited resources or economic incorporation into a management culture. Second, the rules are personal, particularly medical staff, are progressively incorporated into a management culture.
2.3 Resource Allocation and Fiscal Stress

Many authors suggest that resource allocation decision-making is altered when an organization is under economic stress. Schick (1980) discusses the relationship between government budgeting approaches and fiscal scarcity. He describes degrees of scarcity that range from "relaxed scarcity" to "total scarcity" and proposes that governments with resources for budget increments will budget differently than those who are struggling to balance. In Schick's schema, budgeting responses are characteristic of various degrees of scarcity such as a focus on program development in relaxed scarcity, a focus on efficiency and management improvements in chronic scarcity, across-the-board cuts in acute scarcity and "escapist" budgeting and false budget figures in total scarcity.

Several researchers have addressed the impact of resource scarcity on budgeting and resource allocation, examining in particular, if subunit power assumes more importance in times of fiscal stress. The results have been somewhat mixed. Pfeffer and Moore (1980) studied budget allocations at two campuses of a university retrospectively, over a ten-year period. They found that allocations were a function of student enrollment and departmental power, but that at the campus with less resource scarcity, enrollment was more strongly related to allocations and power was less strongly related, suggesting power was more influential under conditions of fiscal stress. Hills and Mahoney
(1978) examined eleven years of budget data from a large university to examine if allocations could be explained in terms of a bureaucratic model of organization or a coalitional model. They examined a time period of relative abundant resources and a period of scarce resources, testing the hypotheses that in relative abundance, universalistic, bureaucratic criteria would be more influential than power and during periods of relative scarcity, the reverse would hold. They found support for these hypotheses and that externally based power during periods of scarcity was a predominant influence, whereas during abundant periods there is probably less need to exercise power as budget increments are provided on an proportional allocation basis. Emmamol and Bourn (1995) compared budget allocation at a university in the United Kingdom during a period of resource scarcity with allocation during resource availability. They found that incremental budgeting occurred during both time periods and that comprehensive budgeting did not emerge as expected during the period of resource scarcity. Contrary to their hypothesis and in contrast to the findings of Hills and Mahoney, externally based power did not have a greater effect on resource allocation during the period of resource scarcity. The authors suggest that incremental budgeting persists because of its ease of calculation, it minimizes service disruption and it reduces politics by bureaucratizing procedures.

Organizations are believed to have a cushion of resources that enable them to adapt or adjust to internal and external changes
There was a weakening of the authority of those administrators who
universities and the city experienced increased budget rigidly.
As the deal with change during a period of reorganization, the
short or budget crisis, the inability of administrators to
under conditions of economic stress, one issue that emerged was
in Rubin's (1980) analysis of these universities and a city:
"goals.
Institutional conflicts, department heads no longer trusted to make
important decisions, departmental expenses were reported, as reWARDS became
way in which expenditures were reported, as changing the
information system with changing in organization or changing the
rates. Also, participation in the organization began to decrease
began to adopt relatively appropriate, such as unconditional
information persisted for a longer period than anticipated and administrators
universities improved. However, uncertainty and economic stress
expenditures were based on criteria and information based in the
base of priority rankings. Following an initial period of chaos,
less "faphazard", loose funds were returned to departments on the
purposes. As the basis for allocation became more explicit and
gathered up by administrators who held such funds, for contingencies
under stress, Rubin (1977) found that intangibility, such much was
stability and even, sustainable. In a case study of five universities
organizational with the ability to make adjustments that ensure
stress, these resources act as shock absorbers, providing the
March, 1993, Cohen & Cober, 1975), under conditions of fiscal
threat that might threaten the organization (Bourgeois, 1981; Cober &
normally controlled slack funds and who had been able to use these as incentives and rewards. She concluded that strategies and tactics varied according to the structural conditions of an organization. If an organization had autonomy in terms of resources, it would try to increase revenues, if it could move expenses forward, it would do so, creating cash flow problems that altered the organization. Rubin concluded that organizations that must balance annually will try to buffer by underestimating revenue and moving towards temporary personnel. The autonomy of the organization will determine how it attempts to re-create budget flexibility, but the re-creation may have some unintended consequences that change the organization. Rubin suggests that in organizations with a weak authority structure and lack of budget flexibility, retrenchment cannot occur so that attempts by outside authorities to exert control by reducing flexibility will be ineffective. She believes that more discretion within reduced funding would be better.

Murray, Jick & Bradshaw (1984) examined the responses of six Ontario hospitals to moderate financial constraints over a four-year period (1976-81). All hospitals had experienced budget cutbacks, which the authors considered to constitute a "moderate long-term crisis" due to funding below the rate of inflation for several years, without a change in demand. Two hospitals were large teaching institutions, two were mid-sized suburban hospitals and two were small general hospitals. Data collection involved
interviews with senior and middle managers, original documents and structured questionnaires. Interviewees were asked to reflect back on the previous five years with regard to changes in procedures, processes, outcomes and attitudes.

The researchers examined three strategies: saving through efficiency measures, raising money and delaying action. The saving strategy was used strongly by two of the hospitals and moderately by another two during the first year and the strategy became stronger until the last year of the period when it diminished. Raising money and delaying action increased over the years becoming the average strategy by the middle of the time period studied. By 1979-80, most hospitals were in a deficit position and had requested additional Ministry funding.

The researchers reported that the perception of administrators changed over the five year period. Initially, they responded to the idea that cutbacks were warranted due to "fat" in the system; however, over time, as cuts continued and as some hospital successfully appealed decisions to the Ministry, administrators began to distrust the Ministry and attributed cutbacks, not to internal overspending, but to external political reasons. The use of the deficit tactic increased as the interpretation of the reason for the cuts changed. Externally oriented tactics increased over the time period, but the researchers noted that none of the six hospitals adopted an overall program review of major programs or joined other hospitals in the region to look at system-wide
rationalization of services.

The researchers conclude that the direction taken in the system was towards greater politicization rather than towards greater rationalism and that both hospital and ministry officials viewed the situation as political and adversarial. As this occurred, the movement was away from internal money-saving, technorational strategies towards money raising and planned deficit strategics. Bradshaw-Cambail's (1986) study of budgeting in an Ontario hospital in 1982 also described an attempt to raise additional funds from the Ministry of Health through political activity.

More recent case reports in the literature suggest that in the early 1990's, hospitals were experiencing budget constraints but did not expect that provincial governments would provide additional resources. Hospitals seemed to adopt cost-cutting strategies, often choosing approaches to decision-making that were new to those organizations. McDermitt (1993) presents a case study of a hospital in British Columbia in which a consultant was hired to develop plans for major cost-cutting in the organization. Rennebohm and Lozon (1992) describe a process used by a rehabilitation hospital in Alberta when planning for a reduction of the 1991-92 budget while providing for new programs identified in a strategic planning process. Decisions were made on an amount to set aside for new initiatives and the amount of total budget reduction. The budgeting process involved committees and task groups that included
staff from all levels, but guidelines, set by the board and senior management, were provided that identified what areas to examine and what areas should remain intact.

Senior managers chose "natural leaders" in the organization to be involved rather than representatives of departmental or traditional levels. A steering committee with senior managers, middle managers and staff specialists developed target reduction figures for each task group. The resulting recommendations exceeded the targets and proposals included reductions in services for which utilization was declining, decreases in middle management and more careful referral to therapies. Those working in task groups felt uncomfortable and awkward however, in that they knew of recommendations that would affect those with whom they worked. In addition, directors of functional departments felt "left out" of the process. One other difficulty encountered was the limitation of information systems, as budgeting and costing had been based on traditional departments rather than the clinical program focus used during the process.

Collins and Noble (1992) reported on a downsizing process undertaken by a community hospital in Ontario in 1991. They noted that previous responses to budget restraints at the hospital had involved across-the-board cuts, a capital spending freeze, a hiring freeze, bed reductions and development of short stay and day programs for surgery. These strategies were viewed as short term ones that were not sustainable and the senior management secured
board approval for a major critical view of programs and structure to streamline services in a way that was consistent with the mission and strategic plan. The hospital underwent a Ministry operational review, at the request of the hospital, and was identified as a low-cost hospital in relation to its peer group. As productivity improvements did not seem likely to generate savings, the hospital's senior management decided to look at program delivery and how services might be streamlined. Two internal multidisciplinary task groups reviewed 42 outpatient and 37 inpatient programs based on the assumption that core programs would be the focus and non-core programs would be discussed with alternate providers in the community. The authors note that participants in the review realized that:

...as the competition for economic resources increased, the health care industry would follow the lead of other maturing industries; that is, providers would begin to emphasize specific areas of health care program delivery and discontinue trying to be "all things to all people" (Collins & Noble, 1992, p. 7).

Although the task groups had difficulty identifying programs to be eliminated, a limited number were identified and recommendations were made that included the closure of 35 beds, tightening admission and discharge criteria, development of consulting services in geriatrics and palliative care and investigation of a psychiatric day program. As the process was completed and implemented within tight time deadlines, the medical staff thought that they had not had enough input into the decisions
and employees were confused about the processes of program review and budgeting. The hospital decreased its expenses by $2 million and did not have lay off any permanent staff, although 50 full-time equivalent positions from all levels were eliminated by attrition.

2.4 Summary

In summary, the literature contains descriptions of hospital decision-makers in terms of a single actor model, a dual coalition model of physicians and administrators, a triad of administrators (most often the CEO), physicians and the board of trustees, a "conflictive equilibrium" that is dynamic, but relatively stable, and a more fluid model of power involving coalitions that shift and change over time. The CEO position in hospitals is described as potentially powerful, for example in terms of access to and control of information, but relatively weak in terms of authority in comparison to other types of organizations. Less is known about other positions within the senior administrative group, the medical staff and the board of trustees. Various views are presented on the relative influence of groups in decision-making, but there is some evidence that group influence may vary by type of decision and across hospitals. Some authors believe that the influence of administrators has surpassed that of physicians over time as hospitals have changed, but others view physicians as controlling decisions. As there have been recent calls for greater accountability by hospital boards, another shift in influence might
be underway; however, such a shift would be undetected in studies that fail to examine this group. There is some indication that senior managers and clinician managers in health care experience ethical problems with respect to resource allocation, but it is not clear if ethical questions arise and are debated during resource allocation decision-making or if senior groups experience such ethical problems.

The literature reflects a variety of perspectives on how resource allocation decisions are made. The processes described include bureaucratic routines, formal analysis of issues, and political struggles. The normative literature tends to emphasize bureaucratic processes and formal analyses to improve decision-making. Most of the recent studies of resource allocation processes in hospitals have focused on capital budgets or technology acquisition, variously defined. Studies that have used survey methods provide findings that tend to describe decision processes in terms of the groups that participate, the kind of analyses undertaken and levels of authority for decisions. The findings of these studies suggest that hospitals do not engage in extensive formal analyses prior to allocating resources for capital purposes. Studies that incorporate interview data on decision processes suggest that participation and influence vary by type of decision and that resource allocation involves political activity and the use of power, something that theorists would predict.

Theories and studies of resource allocation decision-making
under conditions of fiscal stress suggest that organizations adopt strategies and approaches that vary, depending on the degree of resource scarcity, the degree of autonomy of the organization in terms of resources, and degree of budget flexibility. Organizational slack may be gathered up by administrators during fiscal stress as it provides them with some budget flexibility to stabilize the organization. Studies have produced mixed findings on changes in the basis of allocation under fiscal stress; some findings suggest that subunit power has a greater impact at those times while others indicate that following a period of confusion, the basis of allocation becomes more objective, information-based and rational. Studies of hospital decision-making under fiscal stress are rare, but case reports from the early 1990's suggest that new approaches to budget reductions and non-traditional approaches have been taken to make allocation decisions in a constrained economic environment.

There is an extensive literature on decision-making in organizations, but a limited focus on resource allocation decision-making. Despite Pondy's call in 1970 for development of theory of internal resource allocation, such development is not evident in the literature. Many of the studies of organizational resource allocation have been for the purpose of testing theories of intraorganizational power or a strategic contingencies theory of organization, not for understanding resource allocation decision-making. Nevertheless, previous work does contribute pieces, from
a wide variety of perspectives, towards a description and understanding of resource allocation decision-making in hospitals and partial, sometimes conflicting answers to some of the questions that are the focus of this study. In the next chapter, I describe the methods used to address these questions.
CHAPTER 3

RESEARCH METHODS

Ethnographic methods were used to examine resource allocation decision-making in a teaching hospital. The literature review yielded no detailed description of resource allocation decision-making in hospitals based on observational data and documents and I believed that ethnographic methods would permit in-depth study of resource allocation as a "phenomenon within its real-life context" (Yin, 1984, p. 23), a phenomenon that has been rather inaccessible to investigation by more detached methods. Clammer (1984) refers to this approach as "the extended case method" style of ethnography, in which the researcher focuses on "relatively bounded units of behaviour" in a setting or culture to provide building blocks for later theory construction (pp. 79-80). The decision to conduct the study in only one setting was tied to the decision to do an in-depth study of the topic; I knew that such a study would require immersion in a setting and a commitment to spend a substantial period of sustained time collecting data.

3.1 Site Selection and Access to Data

I decided to collect data in a teaching hospital as I believed that the wider range of activities in this type of setting might give rise to more discussions about the allocation of resources. I initiated discussion of the research topic with the Presidents of two teaching hospitals. Both Presidents responded positively to my
request and indicated that, subject to the agreement of other senior individuals in the hospital, I would be welcome to attend meetings and conduct the study. Both of the hospitals seemed suitable, but as Riverview 'a pseudonym' was larger and had a broader range of services and activities, this site was chosen.

At an initial discussion with the President of Riverview, I described my proposed study and explained that I would like access to hospital documents, to administrative, medical and board meetings at which resource allocation was discussed, and the opportunity to interview senior administrators, medical staff and board members. He told me that he would require the agreement of his senior administrative team for me to participate in meetings, so I offered to write a summary and to make a presentation to the senior administration, the board or any groups, based on his advice. He asked me to send him an outline of the research and he would arrange for me to attend a Senior Management meeting.

I sent the President a summary of my research topic, the approach I would be using and my background experience, which was circulated to those attending the Senior Management Meeting (Appendix A). I met with the committee two months before the start of my field work and answered a number of questions regarding the proposed study. The President subsequently informed me that I would be able to start in August 1991, told me that he would arrange for office space, and asked a Vice President to act as a liaison person during my work at the hospital.
When I received approval from the University of Toronto's Human Subjects Review Committee to conduct the study, I began data collection. I was provided with a desk in the office occupied by an Executive Assistant to one of the Vice Presidents. This office was located in the Executivo Offices area, where most senior management, senior medical and board committee meetings were held. During the data collection period, this central location afforded me a great deal of informal contact with the policy makers of the hospital.

As it was summertime and few meetings were held in early August, I was able to spend the first few weeks reviewing documents and minutes of meetings provided to me by the Executive Assistant to the President. I soon learned that it was important to check regularly with secretaries and Executive Assistants to ensure that I was included in meetings. It was arranged that I would be introduced to the Board members at the September Board of Trustees meeting, although I was able to begin attending Senior Management meetings in August. I had to wait until the first Board meeting in September before attending board committee meetings.

Members of senior administration were quite amenable to me attending all meetings, however I still had to seek agreement from individuals for interviews and to seek permission to attend meetings of medical committees. I spoke to the Acting Chief of Staff regarding attendance at meetings that were part of the medical staff organization and he raised the issue with, and
obtained approval from members of the Senior Medical Committee.

At one point during the study, the issue of open board and board committee meetings became a political one for Riverview and although board meetings had always been open, board committee meetings had not been. A policy decision was made to open most of the board committee meetings to the public, with the provision that certain items of a personnel or legal nature would be held in-camera. Once open meetings became an issue, I left board and board committee meetings when in-camera sessions were held. However, for most topics, I had already attended administrative meetings at which the confidential issue had been discussed. In a few cases, the items were considered very "political" and I did not have access to the detailed information discussed at the in-camera session.

Although I sensed that some individuals were hesitant to say things to me in a one-to-one discussion or interview, it seemed as though participants became accustomed to my attendance at meetings and were quite spontaneous during discussions. At one point, a Voco Presidont told me that it was "amazing" what was said in my presence and wondered if it was due to my "low key style". I was careful to keep documents, some of which were considered confidential, secure and I did not leave material in my desk at the hospital. I also was careful not to relay any information from meetings to those who had not attended, despite being frequently asked.
3.2 Data Collection

Three sources of data were used in this study. Data were collected over a period of eleven months during 1991-92. As there were few meetings scheduled during the first month and many senior people were on vacation, I spent most of that time reading hospital documents and attending a few meetings. During the subsequent eight months, I spent approximately three to four days a week at Riverview to attend regularly-scheduled and special meetings and to conduct interviews. When I was not collecting data, I was able to work in the hospital office writing up field notes, reading documents, making interview appointments or making arrangements to attend meetings at the middle management or medical sub-committee level. During the last two months of field work, I only attended senior meetings and spent less time at Riverview as I began to spend more time reviewing and organizing the data I had collected.

3.2.1 Documents

At the beginning of field work, I spent several weeks reviewing hospital documents that would provide general background information on the hospital. These included a hospital history, the mission statement, organizational chart, policy and procedure manuals, annual reports, development plans and the minutes of the board of trustee meetings from the previous two years. Throughout the period of field work, I collected and reviewed documents related to the work of the senior management, senior medical
committees and the Board of Trustees. These documents included reports on various departments, business plans, proposals for new initiatives, financial statements, strategic planning material and the minutes of various meetings. Documents were reviewed, coded with a number, filed and entered into a database management file with a description. References to the numbered code of relevant documents were included in field notes to facilitate retrieval during the analysis and writing stages. Those documents are listed in Appendix B.

3.2.2 Observation

Non-participant observation at formal and informal meetings constituted the major source of data. I attended meetings of senior management, senior medical staff, medical advisory committee, board committee and board of trustee meetings on a regular basis over a nine month period as well as special meetings, such as open meetings with hospital employees, meetings with middle management, and senior management retreats. Although my primary interest was the most senior level of decision-making about resource allocation, I attended a number of meetings at less senior levels to learn how information was prepared and transmitted to more senior levels and to learn more about a particular issue under discussion.

In total, I attended 129 formal meetings:

<table>
<thead>
<tr>
<th>Council Meetings</th>
<th>Senior Management Committee</th>
</tr>
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<tbody>
<tr>
<td>7</td>
<td>25</td>
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I did not participate in discussions at meetings, but rather observed the discussion and took notes as unobtrusively as possible, jotting down points of discussion and occasional quotes from participants. On a few occasions, I was asked if I would take notes for a special meeting, such as a retreat, an evening or weekend meeting and I agreed to do so.

Early in the field work, I noted that several of the secretaries used a tape recorder to record meetings that they used when preparing the minutes. On several occasions during the early weeks of field work, I obtained the tapes from the secretaries to compare these with my notes to see if my note taking had been
accurate and comprehensive. I found that my notes corresponded well to the tapes and that they reflected the discussion quite accurately. However, my notes did not always correspond to those recorded in the minutes of meetings as my notes tended to reflect more of the discussion as well as less certainty about the decisions reached. I spoke to a secretary about the uncertainty of decisions reached in a meeting and told her that a decision was sometimes vague and unclear to me. She told me that she frequently had this difficulty in preparing the minutes, even from tapes, and she had to clarify decisions with the Chair. She said that the Chair sometimes "changed" the minutes or clarified decisions and those were recorded in the "final" minutes that were prepared.

Using a portable computer, field notes were typed in full as soon as possible following a meeting or discussion. Usually, I was able to prepare these notes the same day or the following day while my memory of events was still fresh. My daily notes included the observations made at meetings as well as from numerous casual conversations with individuals in my office, at coffee breaks, before meetings started or in another person's office. Physicians or senior administrative staff would sometimes stop me in the hall, invite me to their office or come to my office to talk about issues in the organization. As I shared an office with the Executive Assistant to a Vice President, there were also frequent conversations with visitors to that office.
3.2.3 Interviews

Interviews were the third source of data. I scheduled meetings with board members, senior administrative staff and senior medical personnel at a time and place convenient to the interviewee. Although participants were willing to meet for an interview, they were very busy individuals and meetings sometimes had to be rescheduled several times before the interview was completed. Interviewees were given a consent form (Appendix C) at the beginning of the meeting and all those approached agreed to an interview and signed the form. All interviewees were asked if they had any objections to the tape recording of the interview. Only two of the nineteen individuals interviewed asked that a tape recorder not be used. Interviews were held with the following persons:

- President
- Chairman of Board
- Chairman of Finance Committee
- Chairman of Strategic Planning Committee
- Chairman of Operations Committee
- Vice-Chairman of Finance Committee
- Executive Vice President
- Vice President, Medical
- Vice President, Nursing
- Vice President, Professional
- Vice President, Finance
- Vice President, Personnel
- Vice President, External Relations
- Chief of Staff
- Acting Chief of Staff
- Chief of Medicine
- Chief of Surgery
- Chief of Obstetrics
- President of Medical Association
Formal unstructured interviews lasted approximately one hour. I explained that the interview would be like a discussion of resource allocation at Riverview and began the interview by asking participants how long and in what capacity they had been associated with Riverview. I explained that I was interested in their perspective on resource allocation decision-making at Riverview and used several questions to guide initial discussion (Appendix D). Other than asking these questions, the interview was unstructured and I did not steer the discussion except to clarify points that had been made. Follow-up interviews were conducted with three individuals to obtain information on specific events and decisions made during the period of field work.

In qualitative research, there are guidelines for assuring that the inquiry is trustworthy, a concept comparable to those of reliability and validity, as they are used in quantitative research (Streubert & Carpenter, 1995). In this study, trustworthiness was addressed through several means. First, I was immersed in the research setting for a substantial period of time, providing an opportunity for repeated observations and discussions with participants in resource allocation decision-making. Second, I used triangulation of methods, collecting data through interviews and informal conversations, review of hospital documents and observations. Third, I followed up on numerous items with participants as I collected data, conducting “member checks” to
validate information or clarify questions. Last, as described in the next section, I established an “audit trail” of documents, field notes and transcripts that provide a record that can be followed by other individuals.

### 3.3 Data Organization and Analysis

Field notes were typed, usually within a day of the events observed. Interviews were transcribed, usually within several days of an interview. Typed field and interview notes were entered into The Ethnograph program and coded, usually within a week of the time notes were prepared. Initially, I used open coding (Emerson, Fretz & Shaw, 1995) and generated a large number of codes, some of which were concrete topics under discussion at the hospital and some of which were conceptual ones relating to the processes that I was observing in the field. During the coding sessions, I made notes on questions that I wanted to follow up on in interviews or conversations and wrote “theoretical memos” on ideas that arose in reviewing the data about concepts and relationships between concepts (Glaser, 1978).

I began to withdraw from the research site when the process of decision-making on the annual operating budget was completed, a proposal for the capital budget was formulated and the occurrence of intensive planning meetings slowed with the arrival of summer. At this point, I had observed meetings that dealt with key events in resource allocation decision-making at Riverview: revision of
mutilarity interdependent" (p. 219) and analyzes them a process
written that "the very organization of the text and the analysis are
described temporal processes, such as decision-making. They also
acknowledge note is appropriate for presentations. The attempt to
was that of writing a chronology, an approach that Hammeley and
form data and the purposes of the research, one strategy adopted
different approaches, and much reflection and thought about the
the literature on writing ethnography, interest schemes of
combination of strategies, a decision taken to combine a return to
approach multiple different programs. I decided to use a
which writing ethnographic texts and note that each
Hammeley and Atkinson (1992) denote the various strategies

3.4 The Ethnographic Text

Literature was consulted to look for comparisons.
As sections were written and revised, data were selected and the
time, and the path was traced, written into stories and compared.
Bechtel experiment, often conducted in an intermittent event over a
specific event. Decisions about a particular item, such as a
voluntary or data, decisions focused on the organization of a substantial
Future Resource Allocation.
Established directions that were intended to have an influence on
attends numerous meetings on strategic planning, a process that
operating budget and development of a capital budget. I had also
the current operating budget, preparation of the next annual
perspective is reflected in the organization of the text. Although data were collected on all discussions of resource allocation, I decided to focus on the two major processes of resource allocation that I had observed at Riverview—decision-making on the operating budget and the capital budget and to describe these in chronological stages.

A second strategy adopted was that of separating description, to the extent possible, from analysis. This choice was made for several reasons. First, I was unable to find any earlier "thick description" of resource allocation decision-making in hospitals and believed that such a description would contribute to the literature on the topic and provide a useful basis for comparison for future research. In using this approach however, I recognize that even the organization of those descriptions has been based on some analytic work (Hammersley and Atkinson, 1983). Second, trial attempts at a fully thematic organization of the text failed to capture the dynamic aspects of decision-making in the organization and to describe the processes in a holistic way. Therefore, the analytic themes, for the most part, have been separated from the description, with links made back to the data and to the literature, where appropriate. In this way, I have also attempted to balance the "tension between analytic propositions and local meanings" encountered in writing ethnographic text (Emerson, Fretz & Shaw, 1995, p. 170). With respect to the description of decision-makers, the level of analysis is the group, i.e., senior
administration, senior physicians and the Board of Trustees, rather that at the level of individuals.

The subsequent chapters are organized in the following manner. In Chapter 4, I provide an overview of the context of decision-making by describing the hospital, with particular attention to the decision-makers, the organizational structure within which decision-making occurs and the perspectives of senior groups on resource allocation decision-making. In Chapter 5, I describe the process of making decisions on the operating budget and follow this description with a discussion of themes in Chapter 6. The process in deciding on the capital budget is described in Chapter 7, which is followed by a discussion of themes in the capital budgeting process in Chapter 8. Chapter 9 contains a summary and conclusions, with a discussion of the implications of the findings for hospital decision-makers, future research and public policy.

In the descriptive chapters (4, 5 & 7), I have used quotation marks in the text to indicate words or phrases that were used by individuals in casual conversation, meetings and interviews, rather than to emphasize ideas. In these chapters, square brackets have been used within quotations to identify where I have changed the text, either for the purposes of protecting individual identities or to improve grammatical flow. In subsequent chapters, ideas from other authors are sometimes presented in quotation marks.
CHAPTER 4

RIVERNW HOSPITAL AND RESOURCE ALLOCATION

As background to the description of resource allocation decision-making, this chapter contains a description of the hospital at which the field study was conducted and of the senior level decision-makers. Some characteristics of the hospital and of individuals encountered during the study have been altered, as well as the name of the hospital, in order to disguise the research setting. In some cases, position titles, gender of participants, and department names have been changed and at times in the text, the title of a group rather than an individual position has been used to identify a source.

4.1 An Overview of Rivernw Hospital

The Rivernw Hospital is a teaching hospital of more than 700 beds located in an Ontario city. The hospital provides a comprehensive range of specialty medical services, some of which are designated as regional programs. The hospital has been in operation for more than 50 years and has a well-established presence in the city. Rivernw has grown over the years and there have been a number of additions to the physical structure, as well as renovations to older parts of the hospital.

The hospital provides a wide range and number of out-patient services, including day surgery, as well as in-hospital care. The distribution of adult patient days for in-hospital care at the
beginning of field work was: Medical--37%; Surgical--44%; Oncology--5%; Obstetrics and Gynaecology--7%; Psychiatry--5% and Geriatrics--2% (document 49). A substantial amount of medical and surgical care takes place in the Clinical Centre, a section of the hospital devoted to a specialty area that operates under the leadership of a physician Director, with input from an Advisory Board. In addition to the adult patient days, there are in-patient days for newborns that amount to about 6% of all adult in-patient ones. There is a large volume of emergency room visits, outpatient visits, laboratory, radiological and other diagnostic tests done on an outpatient basis.

In addition to the provision of clinical services, the hospital has a teaching and research mandate. Students in the health professions at the undergraduate, post graduate and graduate level are provided with learning experiences in all areas of the hospital. There is a Research Centre at the hospital that engages in diverse areas of medical research at both the basic and applied levels.

4.1.1 Decision-making Structure

Three senior groups—the administrators, the physicians and the Board of Trustees—form the top level of the decision-making structure at Riverview. The Board of Trustees (referred to hereafter as the Board) was composed of 21 individuals who provided governance for Riverview. Board membership was made up of men and
women from various professions, such as law, accounting and communications, and most of those individuals held senior positions in corporations and the voluntary sector or owned their own business firms. Three municipal politicians were also Board members, one of whom represented Riverview's district and a second who represented an adjacent district. Three physicians made up the remaining Board members—the Chief of Staff, the President and Vice President of the Medical Staff at Riverview (Document 10).

The Board had three key committees that were active throughout the observation period: Finance, Strategic Planning and Operations. Each of these committees was composed of four to five trustees and was staffed by a designated member of the Senior Management Team, although several members of the team and the President attended monthly meetings of each committee on a fairly regular basis. In addition, an Executive Committee, made up of the Chairman of the Board and Chairmen of all Board Committees, met from time to time to deal with specific issues that arose between Board meetings.

The senior administrators at Riverview were the President and members of the Senior Management Team. The President was also the Chief Executive Officer of the hospital, but two years previously, an Executive Vice-President had been hired to oversee internal operations, freeing the President to deal more intensively with the long-term planning, external relations and major capital projects. A Senior Vice President, who dealt with academic and research
matters, reported directly to the President and also held the title of Director of the Research Centre. As he was absent on leave during most of the field work period, his research responsibilities were carried by the Assistant Director of the Research Centre and his academic affairs portfolio was assigned to the Vice President Medical. A Vice President, External Relations, who dealt with fundraising and public relations, also reported directly to the President.

The Senior Management Team consisted of an Executive Vice President (EVP), Vice President Nursing, Vice President Finance, Vice President Personnel, Vice President Professional Services and Vice President Medical. Members of the team, under the leadership of the EVP, carried overall responsibility for major divisions of the hospital's operations and, as a group, formed a team that addressed management issues from a "corporate" perspective (document 95). The Senior Management Team formed the core of participants at weekly Senior Management Meetings, but they were joined at these meetings by the Chief of Staff and the President of the Medical Association. The Team held occasional off-site retreats that focused on organizational management directions and also held unscheduled meetings to deal with specific issues that arose from time to time during the study period.

The more than 300 active members of the medical staff of Riverview formed Departments organized along traditional medical discipline lines (document 180). Departments combined to form the
made to the monthly MAC meeting. The Chair of Strategic Planning was
the Senator Medical Committee and reports and recommendations were
appointed as the most important issues and concerns were reviewed by
senators. Fortunately, medical policies and issues, particularly medical staff
monthly, a Senator Medical Committee met weekly to address
and hospital staff records. As the membership of the MAC was large and met
hospital bed utilization, ambulatory care, drugs and therapeutics
A series of MAC sub-committees addressed such topics as

administrative arrangements can be made" (document 10).

Facilities are such that the most personnel, professional and
facilities, the attention of beds by department and the development of
decisions affecting patient care including the utilization of
the MAC was to "advertise and collaborate with the administration in
care provided in the hospital" (p. 74). Under批示, "by 1:00 PM,
supervision of medical staff and the quality of medical and dental
to make recommendations to the Board concerning the appointment and
heralds, the Government of Ontario, 1990) the MAC was mandated
decisions at the hospital. Under the regulations of the Public
"for the approval of the Medical Advisory Committee (MAC), the body considered
member of the Medical Advisory Committee (MAC), the body considered
teaching and research. Each Department and Division Chair was a
arrangement that compromised them for their contributions to
mean that they worked under a university-authorized full-time
Approximately one-third of the physicians were employed full-time.
major divisions of medicine, surgery and obstetrics" (document 10).
senior committee and membership included the Vice President of the Medical Association and the Chiefs of the three key medical Divisions at Riverview. Although the President, SVP, EVP, VP Medical, VP Nursing and VP Professional could attend meetings of the Senior Medical Committee, they did not have a vote (document 10).

The position of director of the Clinical Centro was identified in the hospital by-laws as a member of the Medical Advisory Committee. Other than this membership, hospital documents did not identify any specific administrative or medical authority for this position, although discussions in meetings indicated that the physician director did operate quite autonomously, much to the chagrin of several senior administrators, senior physicians and board members who thought that they were accountable for decisions made in the Clinical Centro (Notes, December 2; February 4, 10, 24, 27). Considerable resentment of the Clinical Centro was expressed by physicians who thought that the Centre did not always acknowledge the contribution that other medical services made in supporting the work and success of the Clinical Centro (Interview 13).

At the beginning of the observation period, the position of Chief of Staff at Riverview was vacant and in accordance with the by-laws, the President of the Medical Association filled this role until there was a replacement. After approximately a month, a Division Chief was appointed as Acting Chief of Staff until a Chief
of Staff was appointed by the Board on the recommendation of the MAC. The new Chief of Staff, formerly the Vice President of the Medical Association, occupied this position for the last four months of the data collection period. The Chief of Staff had responsibility for the supervision and quality of medical care within the hospital and carried disciplinary authority with respect to medical activities (document 10). In differentiating his role from that of other senior physicians, the new Chief of Staff explained that the VP Medical was "more or less a corporate person", that the President of the Medical Association was "the union person" and that he was "in between", but that together, they had complementary roles in representing the concerns of the medical staff (Notes, February 17).

In addition to the above-mentioned committees of each of the senior groups, a "Council" had been established to enable the President to bring senior physicians and senior managers together for a discussion of issues that required the input of both groups. There was also a Fiscal Advisory Committee (FAC), established by the provincial government under the regulations of the Public Hospitals Act (1993). This regulation was designed to promote consultation with employees and mandated the committee to "make recommendations to the board with respect to the operation, use and staffing of the hospital" (p. 73). At Riverview, the FAC met to discuss the operating budget status, program initiatives and cost-saving measures (document 156). Members of the Committee
represented medical, nursing, support and other staff and meetings were chaired by the VP Nursing, but attended by other senior managers. As some representatives expressed concern about their role in keeping their groups informed, the VP Nursing had met with them to clarify that the Committee's purpose was not to disseminate information or be a Union committee, but rather to ensure that Riverview had input "from the general population of the hospital staff" (documents 156, 197).

4.1.2 Resource Allocation Plans

Past resource allocation decisions were reflected in Riverview's annual operating budget and a five-year plan for capital expenditures (documents 79 & 19). Riverview's operating budget was developed annually by compiling submissions from management personnel in all functional divisions of the hospital. The process began in the Fall of each year and the target was to have a Board-approved budget by March 31, the end of the fiscal year. Once a budget proposal was formulated by the Senior Management Team, it was presented to the Senior Medical Committee and then forwarded to the MAC, the Finance Committee and the Board of Trustees for approval. This process had been followed for the 1991-92 operating budget, although I was told that the process had been somewhat protracted that Spring, so that the Board did not give final approval until April of 1991 (document 263).
The 1991-92 operating budget was summarized in a "budget book" that was made up of four key sections: a "service budget" and "non-service budget" for the hospital core that included all parts of Riverview except for the Clinical Centre and a service and non-service budget for the Clinical Centre (document 79). The book contained explanations of the revenue and expenditure lines in those components. The service budgets seemed to include all revenues and expenditures that related most directly to patient care services and these totals showed a slight surplus for both the hospital core and the Clinical Centre. Revenue lines were for Ministry of Health (MOH) base funding and funding for special purposes, income from private and semi-private bed charges (known as bed "differential" income) and other non-MOH sources of income, such as that from other provinces or Workers' Compensation claims (document 79). Major line items in the expenditure portion of the service budget represented the portfolios of the Vice Presidents, such as nursing services, medical services, professional services, administrative and support services, plus an amount for administration. Employee benefits, pay equity, operating leases, education, bad debts and a board contingency fund also had separate expenditure lines.

The non-service budget for the hospital core included research revenue and other revenues, such as a portion of bed differential income, marketing projects and "ancillary" operations. Expenditures included those on research and recruitment, patient
and financial information systems, interest payments on loans and expenses such as non-shareable depreciation (an item not recognized by the MOH as an expense) and shareable depreciation (equipment replacement costs shared with the MOH). The Clinical Centre's non-service budget showed income from the MOH and research as well as expenditures for interest payments and shareable depreciation. While the non-service budget for the Clinical Centre showed a slight surplus, the one for the hospital core showed a deficit of more than $4 million for the current year and a similar deficit for the previous year (document 79). At the end of the two non-service budgets, non-cash items such as depreciation and accrued sick benefits were added back into the total to identify an amount that was "transferred to capital".

During my first weeks at Riverview, I occasionally heard conflicting references to a deficit. When I questioned this, the answers were sometimes confusing:

INTERVIEWER: I've heard that there have never been any [deficits] and yet, I've heard that there have been. I'm not sure--Do you know what I'm talking about?

VP: Yeah. Well you see, it's a question of what you call a deficit. We have separated into two components--one called service and one called non-service. The service was more or less referred to as the operating budget and the non-service--more, I guess, the capital budget. I mean, the monies that were to go to capital somehow, were included in this budget....And people sort of overlooked the fact that really there is only one pot....

INTERVIEWER: But if you took it as an overall...there were deficits.

VP: Not substantial ones...and only a couple of years, but
the other uh, uh, issue is when you talk about deficits. And sometimes it's very difficult...you can get five hospitals and three will say we have deficits and two will say we don't have deficits and we're not comparing apples to apples because of depreciation. (Interview 3)

Although the budget book did not combine all of the two service and two non-service budgets and present a grand total for Riverview, if one did so, the overall deficit for the 1991-92 fiscal year amounted to $3.6 million and it was this deficit to which the VP Finance and others referred when discussing the deficit (document 49). The administrator explained that the Ministry funded only part of the amount included in the budget for equipment depreciation and did not fund the building depreciation amount at all. Those amounts, plus an amount for accrued sick benefits, were non-cash expenses that were used for capital equipment and projects. In years in which there was a deficit, lesser amounts would be used as revenue for the capital budget. In other words, the cash flow provided by such expenses could be used to cover operating deficits if these occurred or, as was the more usual case, was used to fund capital equipment expenditures or capital projects. As expenditure amounts for the building and shareable depreciation would not be part of the reports to the MOH, Riverview had not had a deficit from the Ministry's perspective.

In the Spring of 1991, the Board of Trustees had approved a deficit budget and a Board member told me that "there was some pain about that" but that the Board had reluctantly approved it based on senior management's assurances:
BOARD: The [EVP's] pitch was sort of, over two years we can get this under control, don't panic now and start layoffs because you'll be hiring in a year. So let's just sort of think about it in a two or five year time frame and uh, the board agreed--but at the end of that time frame was a balanced budget. And on the financial side, that's where the board's at. (Board 10)

The Senior Management Team was not certain however, that they would receive all the projected funding for the year and they had almost immediately established a series of "budget initiatives" to reduce expenditures and generate revenues over the 1991-92 budget year. Their initiatives totalled more than $5 million from a combination of selected expenditure reductions and additional income and each initiative had a target amount (document 49). Every month, senior managers reported to the Finance Committee on how close they were to reaching each target by the end of the fiscal year. These initiatives included operational reviews of nursing, housekeeping and dietetics, non-renewal of contracts, reductions in discretionary expenses and savings related to staff turnover. A VP told me that during the early summer, senior managers had reviewed the organizational charts from all divisions of the hospital with the intent of reducing the layers of management personnel and that they were "ticking off items" on their initiative list (Interview 4).

A five-year capital plan, often referred to as the "capital spreadsheet," had been presented to the Board in June 1990 (document 19). The plan consisted of annual projected revenues and expenditures for a five-year period and included items for major
ronovation projects, major new equipment purchases, such as Magnetic Resonance Imaging (MRI) equipment, and major capital projects that were part of a third-phase "redevelopment" plan (documents 19 & 20). Projected revenue in this spreadsheet included estimated annual amounts from depreciation and other non-cash expenses, anticipated and existing capital grants and estimated amounts from fundraising and other non-MCH sources, such as a portion of revenue from private and semi-private room charges. Based on this plan, the necessary "bridge financing" was identified at specific time periods in the five-year plan. At the beginning of field work, the outstanding loan balance was $7.7 million (document 49).

One component of the five-year plan was an annual allocation to meet capital equipment requests from all parts of the core hospital. The Clinical Centre did not participate in this fund, but rather used its own donations and operating funds for this purpose (Notes, January 20). Every year, a committee chaired by a Vice-President and composed of representatives from each functional service and five physicians, reviewed equipment requests submitted on special forms. The committee had been in existence for two years and replaced the traditional "envelope system," whereby each Vice-President (VP) had received an amount that could be used for capital equipment within their operating division. As there had been millions of dollars in requests that could not be met and there were concerns about overlapping requests and failure to
consider hospital priorities as a whole, the committee system had been put in place by senior management (Interviews 1 & 4).

Other major components of the five-year plan were major construction projects. Once the five-year plan was established, the President forwarded items in the plan to the Finance Committee and Board for spending approval. He had done so in February, 1991 when the Board agreed to maximum amounts for three of the priority projects in Riverview's third phase of "capital redevelopment"—a clinical investigation unit (CIU), an operating room (OR) project and a third phase expansion of the Research Centre (document 23). The capital budget, although established on a five-year plan basis, was subject to change for a variety of reasons: changes in estimated revenues, delays in planning or construction for major projects, the willingness of the MCH to provide capital grants and annual variations in income and interest rates. Expenditures on approved projects were recorded by the Finance Department, based on capital work done under the direction of the Planning Department. The Planning Department worked closely with the President, who brought capital items to the Finance Committee when tenders or more detailed approvals were required.

4.1.3 Strategic Planning

Although there was no formal strategic plan at Riverview, a small group of physicians had developed a document in 1989, titled "Looking to the Future" (document 30). This document contained a
included senior physicists, the chair and vice chair of the board
do chair by the president. Membership on the steering committee
(nearer called the steering committee) would be established and
It was agreed that a strategic planning steering committee
 strategic plan (document 16).
consultant be hired to help with the process or developing a format
was made by the president to key board members that an outside
As a result of the meeting with these physicists, a recommendation

Folks, interview(s)

Now I said, "this is not how you do strategic planning,
and a new date announced that this is when would sort of be,
and they got together and checked it up on a trip chart in an hour
BOARd: And the whole truth was, well there was five or six of

And the four folks:

member told me that senior physicists had refused to "buy in" to
because a strategic plan was not in place (document 16). A board
allocation recommendations to the board or at a scheduled weekend
physicists that the modal staff was not ready to make resource
In September 1990 however, the president was told by senior
120 By 1992, subsequent capital/redevelopment proposals were then
120 By 1992, subsequent capital/redevelopment proposals were then
President reported on the increases in research grants and
President reported on the increases in research grants and
"into place" (document 17). As the retreat, the senior vice
that year, two senior board presentations on these look and made
proposals for "four look" for the hospital at a board retreat in
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Strategic Planning Committee and the Senior Management Team. The Steering Committee was to work with the consultant and report to the Board's Committee. The Board Committee was composed of Board members, but meetings were normally attended by members of Senior Management. The university with which Riverview was affiliated was also embarking on a strategic planning process to "establish lead hospitals for most programs, identify Centres of Excellence, make program sites of new high technology equipment" (document 21). It was agreed that Riverview would participate in that process, along with other teaching hospitals (document 74). That process involved the establishment of a committee called the "Rationalization of Clinical Services" (hereafter called the Rationalization Committee), which included hospital CEOs as members.

The strategic planning consultants interviewed 36 senior managers and physicians, conducted six internal focus groups with 33 middle managers and examined hospital data from the Hospital Management Records Institute (HMRI) and other sources to describe Riverview's activities and "market share" of clinical services (document 165). In presenting preliminary findings, the consultant noted:

- strong support for the process
- desire for more specificity on the mission statement,
- foci (there is not unanimous agreement on the four foci established in 1989)
- hospital perceived as having a foot in the past as it is perceived to be a community hospital. Those interviewed
supported moving forward and becoming more specialized in certain areas, but did not want to lose the hospital's balance on the need for enhanced communication, networking, negotiation, etc. both internally and externally (document 74).

A retreat involving Board members, senior medical staff and Senior Management was held in June 1991. At the retreat, participants developed an initial draft of a mission statement, draft criteria for "programs of excellence", role statements for patient care, education and research and value statements (document 46). During the summer of 1991, the draft mission statement was discussed at a medical staff meeting and in focus groups with department Directors. In addition, questionnaires based on the draft statement were circulated to more than 100 individuals (document 16S). The President hoped to complete the strategic plan by the Fall of 1991.

4.2 The Decision-makers

4.2.1 The President

The President and Chief Executive Officer had been in his position at Riverview for approximately 15 years and considerable changes had taken place at the hospital during that time, notably in construction of new facilities and extensive renovations to the original buildings. The President was perceived by others as "a builder" who had brought change to Riverview and one person told me he had taken "the bull by the horns" and had been able to "push [a project] through to completion" (Interview 14). His strength was
seen by some as his "vision" and his ability to focus narrowly on what he was pursing (Interview 1). Not everyone agreed with his vision or approach, but many believed that he had positional power that greatly influenced decision-making (Interviews 4, 9, 14, 20, 21; Notes, August 28 & September 4).

Several years earlier, the Board of Trustees had "encouraged" him to hire an Executive Vice President to whom he could delegate responsibility for "operations" and enable him to devote his energy to external relations and long-range planning (Notes, August 28; Interviews 1 & 3). Although it was recognized that there was a need for him to pursue funding and planned capital projects, there was concern by some that in withdrawing from operations, the President lost touch with internal developments at Riverview. This concern was one of the reasons that the EVP had suggested that a Council, as described earlier, be established (Notes, August 20, October 2). The Senior Vice President (SVP), who was on leave during most of the observation period, was reputed to have a key relationship with the President and in the view of others, the President was influenced by him with regard to the role of research in the future of the hospital (Interviews 17 & 21).

The President's responsibilities were more future oriented and were reflected in his leadership in planning for major capital projects and his chairmanship of the Steering Committee on Strategic Planning. The President saw his role as one of looking ahead to the future and ensuring that the desired future would be
achieved:

PRESIDENT: And I see my role, which relates to financial planning, as being...My job is to be the captain of this great, big aircraft carrier and to make sure that I look a way out to sea--five or ten or twenty miles now--and to see what squalls are coming and to see what reefs are out there and to manoeuvre my way around the squalls and to get through the thunder storms and avoid--beaching us and make sure we get to where we want to go, which is twenty miles out. (Interview 7)

As reflected in the above quote, the President had to anticipate changes in the environment that might affect Riverview and therefore he had responsibilities for relationships with external organizations such as the Ministry of Health, the District Health Council, other health care institutions and the local community. At one point during the field work, he spoke to both the Executive Committee of the Board and to the Senior Management Team to indicate that he should increase his external activity so that his work was "95 per cent external and 5 per cent internal" (Notes, December 2). Members of the Executive Committee and the Senior Team were both concerned that 95 per cent was too much and that he would be "out of touch" with internal issues. The VPs told the President that as he had to guide issues through the Board, it was important that he be knowledgable about them. The President acknowledged that he would have to be briefed regularly by the EVP, but he indicated that they would have to work out a way to enable him to increase his external activities.

The President had a key role in conveying information between the Board and Senior Management. Although he did not regularly
participate in Senior Management meetings, he occasionally called special meetings and frequently attended portions of Senior Management meetings to convey Board concerns. His references to telephone calls and meetings with Board members indicated that he was in frequent contact with them, particularly the Chairman of the Board (Notes, August 21, September 3, December 2, February 17).

When I asked the President about principles or assumptions he considered in resource allocation decision-making, he told me that the one goal he kept in mind was that he would "like [Riverview] to be the very best academic health sciences center possible" (Interview 7). He discussed the need for the hospital to change and become more specialized and he acknowledged that some services would have to be moved to other hospitals. He said:

PRESIDENT: I mean, my simple goal is to hopefully in the long run to compete nationally and internationally and to do that we have to make decisions which try to reflect that. But that's going to be really hard over the next three or four years when finances and resources got so very tight and therefore, our planning has to be really good. And our foci or programs of excellence have to be really tight. And we all have to agree on that. Otherwise, we'll just water down things to no avail and the opportunity will slip on by.

INTERVIEWER: Uh huh. When you say "compete nationally and internationally," you mean in terms of patient care, research and teaching?

PRESIDENT: In a selected few corners. (Interview 7)

4.2.2 The Senior Management Team

Members of the Senior Management Team focused on the internal management of the institution and during interviews, their
discussions centred more on past management practices and how these were changing rather than on the overall future directions of Riverview. The team was a fairly new one:

The EVP had been at Riverview for two years, having been recruited from a CEO position at a community hospital.

The VP Nursing had been promoted internally from middle management and had been in her position for six years.

The VP Finance had been recruited from private enterprise four months prior to the study period and was the newest member of the Senior Management Team, in the sense of being new to Riverview.

The VP Personnel had held various senior positions in the hospital for 20 years and his current position for four years.

The VP Professional had previous middle management experience at various hospitals and had been with the hospital two years.

The VP Medical was appointed to his position one month prior to the study period and was therefore the newest member of the Senior Management Team. However, he had worked with that team during the four previous years in his capacity as Chief of Staff.

On his arrival at Riverview, the EVP found that there was little formality in the management committee structure in that "about 30" directors and senior managers met to discuss issues of the week and there were no recorded minutes. He eliminated those meetings and established the weekly Senior Management Meetings. The EVP told me that the Senior Team was starting to work together and that "I'm a firm advocate of dealing through the VPs". He told me that although he went to the VPs for solutions, "In a very non-threatening way, I reserve the right to make the final decision...I'll try and get a compromise" (Interview 3).
The DP andca.re.ed service (documented) were not a service. The YE of
committee 1, 2, 3 and 4. The YE Finance total was strenuous.

Particularly, the relationship between the operational and capital
was bringing about a fuller understanding of hospital finances.
Our members of the poster team indicated that the new YE Finance
In addition to a move towards a "corporate team" approach,

the YE and related services (documented) were not getting
the YE and related services (documented) were not getting

nurses had developed a proposal for a form of program management of
meanwhile, a working group of poster supervisors, administrators, and YE
between nurses and several senior management levels, but in the
they discussed the implications of such a structural change at two
...different locations of nursing, medical, professional and other services.
incorporated into other programs, rather than the current
...would be a move to "program management" whereby hospital services would be

members of the poster management team had been experiencing a

(Interpreted: "There were no major changes in the organization, the doctors ter that I think has been a major
in your department, the better that was not one of us doctors
in your department, the better the collaboration, the better
...and they had their own mechanisms worked out.
...to each other. We've been in place a long time so they knew how each
people or whatever. We had a very stable senior team before.

In fact, we've got..."...we had a very stable senior team before.


We explained the changes in how senior management worked.


They pointed out how the changes in how senior management worked.


As a group, the trea (interpreted: "Interpreted: "There were no major

...and they were all experienced and had worked together for years."

Several members of the senior team mentioned during interviews,

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formal and although the VPs may have been very familiar with the 1991-92 operating budget was prepared according to the traditional position was filled (Interposition 1:3). During that six months, the consolidated by an accounting VP Finance for about six months until the following VP Finance had worked in taxation and he was because the former VP Finance had worked in taxation and he was that there had been "confusion among senior managers in the past the other VPs viewed the VP Finance as the expert and told me that they knew, I mean, it's all bullshit, you know. It's a joke. I don't mean it on the spreadsheet—yes, sir. It's a joke. I don't mean it on the spreadsheet, it was like you won't you know, you could hear people say—people never saw
Precent and the former VP Finance: "Famous caps [capital] spreadsheet was developed and monitored by the another administrator committed that view and told me that the money. (Interposition 2) But we were just footing ourseleves. It's all not very part of the deal was to try and stick to it in the building somehow. So the deal was to try and stick to it. There was never money. Anybody that had to do with building—there was never money. Yes, but the way it was presented for years. It was such a scenario and "non-operating" or capital was consulting. (3) One administrator told me that the difference between for capital projects seemed to constitute a "shady" part (Interposition for several VPs told me that there was a kind of mystery and non-operating funds, capital funding came from available cash (Notes), and capital spending had been made independently; yet they had to make sense. He said that in the past, decisions about operating

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future, they tended to focus on other factors affecting decisions. In the
short-term, resource allocation would affect resource allocation decisions. In the
long-term, changes brought about by strategic change and reorganizational
strategies, planning during intercalations, were several acknowledged
members of the senior management group made few references to

In this context, services were to be avoided (intervened 4, 9, 10). Of the
VPS told me that several cars were a priority and whose costs
sustained primarily were for resource allocation at 75% levels. All
tickets (Nones, August 14), when VPS were asked about what the

"ticket" and people would have to face the fact that money was

in months. In the view, there would have to be a "real change in
situation occurred so go downstream at intervention over the past 2
hospitals’ contractual services and noted that the contract
for this position, he told me that he had examined 12 years of the
2, 4, 6, 14. When I entered the VP Finance, who was currently
at which difficult allocation decisions were required; intervention 4,
most VPS believed that they had reached the point of intervention 4,

problem areas (Nones, September 6).

intervened 2, 5). One of the key
understood the change in the Finance department. In the Finance
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within their areas of responsibility, such as quality of care or safety and legislative requirements (Interviews 1, 2 & 4). One of the Senior Managers, who supported a "planning document which is rational and thought through", expressed some of the cynicism that was heard at times during discussions of strategic planning and regional rationalization:

VP: Or do you just have the typical back room decision-making where a couple of CEOs get together and say, "Well you take this and I take that". I mean [the President] has made comments about mergers being decided on the end of the dock at lakes when two CEOs are sitting down having a drink and saying "Let's merge". And you know, a lot of that--there's truth in that, in how decision-making is made. (Interview 4)

4.2.3 The Senior Physicians

The senior physicians most involved in the operating budget deliberations during field work were the Chief of Staff, the President of the Medical Staff, the Chief of Medicine, the Chief of Obstetrics and the Chief of Surgery. These individuals also formed the core of the Senior Medical Committee and, with the addition of the Associate Director of the Research Centre, were the senior physicians that attended Council meetings.

Senior physicians believed that they did not have sufficient input into resource allocation decision-making at Riverview and that a "program management" approach should be implemented. One Department Chief told me that he should be in charge of the resources for his department that were currently controlled by the Department of Nursing and the Senior Vice President (Interview 17).
Another Chief told me that his lack of authority to allocate resources meant that he was unable to influence physicians within his department with regard to resource utilization. In his view, the existing authority structure would make future reallocation of resources within the hospital unlikely:

PHYSICIAN: It's going to be very hard. Uh, and part of the problem is that if in the department we say, X [a specialty area] is not going to be a major focus for this institution, I'm going to have to turn around and say to my division head, "Look, [medical specialty area], ain't going to cut it....you're just not going to come into line for any resources. Yet when we have to take resources, it's gonna probably represent a shift in your area to the other". You know what his answer's going to be? "Piss on you because you don't control any of the resources." (Interview 13)

The senior physicians held mixed views on strategic planning, but all of them thought that a plan would have an impact on resource allocation in the future. Two academic physicians, who were supportive of and active in the planning process, indicated that their recruitment plans were affected by the directions taken by Riverview (Interviews 13 & 17). They both expressed the view however, that physician impact on resource allocation decision-making would require changes in organizational structure, with a stronger role for physicians in management. One explained that his only authority in resource allocation related to recruitment and that, in the absence of a strategic plan, he had to "play the game" to convince others. If successful, other parts of the hospital had to cope with the impact of that recruitment "after the fact" (Interview 13).
Most physicians described strategic planning in terms of regional rationalization and Riverview's decisions on programs of excellence. They indicated that they recognized the need for Riverview to change, to become more specialized, to turn over some services to other hospitals and to choose key areas for development, but some expressed mixed feelings:

PHYSICIAN: Um, and I hope that when the dust clears, that we have a hospital that still recognizes its responsibilities to the community. I have concerns about some of the people that are driving the strategic planning process pay lip service to community responsibilities but really are driving it for their own agenda... I see some people envisioning that the hospital is going to be this world famous institution. And I just wonder if that has more to do with their egos than with the true needs of the [local] community and the surrounding area. And, so, that's what really concerns me. (Interview 13)

One physician thought that the President was not committed to the strategic planning process, that he regarded it "as an intrusion" and was not prepared to make the "tough choices" required. He thought that the "medical leaders" were prepared to do this however:

PHYSICIAN: And we'll fight to balance [services]. Uh, some of the areas, we're in pretty good agreement....But everyone is willing to say, "Yeah we're going to have to make some choices. So, let's get the criteria, fixed up, out on the table and let's make some decisions based on those criteria" And then let's have the big, big, big, messy political fight about saying, "I'm sorry".

INTERVIEWER: "You don't meet the criteria".

PHYSICIAN: "You don't meet the criteria". But that's not, I mean, I've been here for x years now. Uh, and it ain't going to happen. I don't think. (Interview 13)
4.2.3 The Board of Trustees

Each year, the Finance Committee of the Board discussed and reviewed the proposal for an annual operating budget and then made a recommendation to the Board of Trustees. Approval of the operating budget usually took place at the March Board meeting, just prior to the start of the new fiscal year. Major changes in the operating budget or financial policies also required Board approval.

Several individuals told me that there had been dissatisfaction with earlier financial administration at Riverview (Interviews 1, 3, 13 & 19; Notes, August 23, September 6). According to interviewees, the Board of Trustees had been unhappy "that numbers were always wrong" and "there was no input", so changes were being made as "traditionally, [budgeting was] highly driven by Finance and we're stopping that" (Interview 1 & 3). In part, Board complaints about the "financial side" were said to be the reason for some recent changes in the Senior Management Team.

Several Board members expressed uneasiness about their lack of knowledge of the budgeting process at Riverview and lack of information with which to make decisions:

BOARD: And it's difficult for a lay board to deal with some of the issues, like, in terms of the budget. Because we aren't involved in this business. We all come from very different businesses. In no particular order, my thoughts, our major concern is process. Is there a process in place--a full process--that we feel comfortable is there and that is functioning and that therefore the end result of that process will be appropriate options or recommendations for our review.
Uh, so we begin from that process or from that point, rather. Because in the past, that's been a problem. We weren't sure what the process was for development of the budget. We had a sense that it was one individual sitting in an office by themselves, cranking out numbers with absolutely no input. (Interview 12)

In addition to the difficulties of being "laypersons," some Board members were mistrustful and weren't confident that they were fully informed:

INTERVIEWER: You were saying you find that resource allocation is difficult to sort out.

BOARD: Very. It's difficult because it's hard to get straight answers. First of all, it's very difficult for someone from outside. I'm not a financial wizard. It's not my field. So I have a great deal of trouble coming to grips with how resources are allocated by the government to the hospital in the first place and how the budgeting is done in the hospital....So I have some real fears, first of all, that the people on the finance committee don't know the whole story, and that we're ignorant of the process, and then--and I'm going to be very frank with you--that sometimes we're not told everything. That decisions are made before we have an adequate opportunity to look at them. (Interview 9)

One Board member seemed to accept that hospital senior administrators had to be the ones actually making decisions and compared hospital Board power with that of politicians in municipal government and members of boards of education, who he considered to be more "in control" vis-a-vis senior staff:

BOARD: The hospital is the next step down where the thing is so complicated and we're all laymen and we have no idea what the thing is all about, that it literally takes years to even find out where the levers are. And my sense is that staff largely has their way with us. Senior administration largely has their way with the Board. Uh, and when we do catch them (laughing), we sort of broad brush the thing too much....So I think, I mean for a long time and it's still now, I don't think I have enough knowledge to be a decision maker about resource allocation. Make a policy and leave it to the senior
Board members expressed unease about their ability to make strategic planning, indicating a lack of a clear strategy or decision-making process at the corporate level.

INTERVIEWER: So this will be a test, in a sense.

THE BOARD HAS NO POWER OVER THAT, IN TRUTH.

I come from, is about, is making decisions on resource allocation. I mean, there's no question about it. What the board has no power over that, in truth.

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decisions on medical appointments, bed closures, capital equipment acquisition and capital projects without a better sense of what the hospital "wanted to be". All of the Board members interviewed thought that a strategic plan would help them "get a handle" on resource allocation at Riverview:

BOARD: Well I think historically, we don't get much of a view of resource allocation. To a large extent the Board is looking at the bottom line. The decisions are all being taken in the back rooms....As things shrink, the Board will be more involved in resource allocation. And as the strategic plan gets implemented, we can push that process on and we get involved. Then there's a measure—you know there's a benchmark? Where they're going to appoint [a physician]. And you say, "Wait a minute, why are we appointing him, how does that fit into the medical manpower planning which is being developed with the strategic plan?"....I mean [the Chair of the Board Strategic Planning Committee] has been fighting me for three years about this—we have to get the strategic plan in place. I'm saying, "Oh, motherhood" you know, why are we bothering?" Well, you bother because you can drive other things off it. (Interview 10)

While the foregoing provides some of the background with regard to resource allocation decision-making at Riverview, what follows in subsequent chapters is focused on events during the study period. During that time, decisions were made about reallocating the 1991-92 operating budget, the 1992-93 operating budget was formulated and the capital budget was reformulated. The next Chapter is focused on decision-making about the operating budget.
ALLOCATING THE OPERATING BUDGET: A DESCRIPTION

During the period of field work, there were two operating budget proposals developed that required resource allocation decision-making by Riverview's senior groups. The first proposal was initiated in August 1991 and decision-making proceeded over a period of approximately six weeks, during which time the 1991-92 operating budget was revised. This mid-year revision was initiated by the President in response to reports that anticipated revenues would not be forthcoming from the provincial government and fears of the mushrooming effect that a "shortfall" would have on the existing budgeted deficit unless adjustments were made. The second proposal resulted from the annual preparation of the operating budget for the next fiscal year (1992-93). This process was initiated by the Senior Management Team in September 1991 and continued until approval of the operating budget by the Board in March 1992.

Allocation of the operating budget involved three phases that overlapped somewhat in time, but that occurred in an orderly sequence. In this Chapter, a description of decision-making at Riverview is organized in terms of these phases: framing, building and selling the budget proposal.

5.1 Phase 1: Framing the Budget Proposal

Senior administrators were key persons in establishing a framework for the development of proposals for the operating budget. In initial discussions of the task, they assessed
Riverview's environment, drawing on their contacts within the hospital and health care network. They also considered Riverview's past decisions and the potential directions for the hospital that had been suggested so far in the strategic planning process. Using rough financial estimates and calculations of what limitations there would be on spending, they generated potential strategies and gave direction on who should be involved in the next steps of proposal development.

5.1.1 Riverview's Environment.

Budget planning began with rumour and speculation about funding from the MOH, but no formal communication from officials at the Ministry. When the President called a Council meeting to discuss revision of the budget, he brought newspaper clippings that reported stories of bed cuts in other cities and of the refusal by the MOH to provide hospitals with additional funding (document 32). He told Council members that based on his discussions with a local Member of Provincial Parliament and other sources, money to cover increases from contract settlements and pay equity adjustments would not be forthcoming from the MOH as expected (Notes, August 21). These stories were reinforced later when the Executive Vice President told senior managers and physicians of similar assumptions being made by other hospitals and rumours that the government would announce by the end of September that there would be no additional money for hospitals (Notes, August 26 & 28). When planning began for the next fiscal year's budget, informal reports again were used as a basis for planning. At that time, rumours
circulating in the hospital network led to predictions of government funding increases for "base budgets" in the next year. The EVP reported that other hospital administrators present at a meeting he had attended thought that the "magic number" was two percent (Notes, September 30).

Potential changes affecting Riverview in the long term were suggested when the President reported on a health consultant's warning that there was a move to reduce the number of teaching hospitals in Ontario (Notes, August 26, September 3). The EVP noted that there was a similar trend in Quebec and he had heard that one teaching hospital would disappear in Montreal (Notes, September 3). Awareness of such threats to teaching hospitals was evident in discussions at the Strategic Planning Steering Committee. Some physicians expressed their concern that the public did not understand the role of a teaching hospital and tended to think of Riverview as a community hospital that met all of their needs. For that reason, some senior physicians wanted research and Riverview's connection with the university to be more "front and centre" in the mission statement (Notes, August 28).

5.1.2 Past Decisions and Future Goals

In framing the budget revision process, the President emphasized the goal of capital redevelopment while pressing for a balanced budget. Although the Board had reluctantly approved a deficit budget in the Spring, the President advised that with potential deficit growth, Board members were suggesting to him that capital redevelopment should be postponed. He said: "You know
what postpone means--it will never get done" (Note, August 21). As Board members were telephoning him and were "very nervous that we can balance the budget and begin [two capital] projects this Fall," the President wanted the budget to be revised (document 35). He then identified four hospital goals as: 1) balancing the budget to have a new one by the beginning of October, 2) to start the capital redevelopment projects in the Fall 3) to achieve accreditation in the Spring and 4) to finalize the strategic plan in the Fall (document 35; Notes, August 21).

The President also expressed concern about the impact that budget cuts could have on the level of service that the hospital provided to the community and emphasized that they should try to avoid layoffs, two traditional concerns of Board members. Perhaps because of these concerns, at his next meeting with Senior Management, he presented a slightly revised set of goals: 1) balance the budget, 2) meet the community service needs, 3) rebuild Operating Room and continue "intellectual growth" via redevelopment projects and 4) maintain the highest accreditation standard (Notes, August 26). The term, "intellectual growth" was made in reference to the Research Centre project, but it also referred to the Board's intention to name specific areas as "Programs of Excellence" that would require reallocation of funds (document 31).

The hospital goals, identified by the President as guiding decision-making about budget revision, underwent changes and re-emerged later as "budget principles". In the initial period of discussion about the 1992-93 budget, the Senior Team discussed
whether or not they should set a balanced budget as a goal, given that a large amount of savings would have to be found. They noted that if they took all of these savings out in one year, it would have an impact on the capital projects and they believed that the President "doesn't want capital touched" (Notes, October 17). However, they had told Board members that they would balance the budget for 1992-93 and as they believed that the problem would be compounded in the subsequent year, they decided to plan for a balanced budget. In response to a request by the Finance Committee to provide the "early thinking" of management on the budget, the EVP reported that the principles that would guide the budgeting process were: 1) a balanced budget 2) maintenance of service levels and 3) layoffs as a last resort. He also hinted that this time around, the last two principles might be breached (Notes, November 19).

5.1.3 Financial Estimates

The decision process was framed by a series of financial estimates that led to predictions about the "bottom line", should no changes be made. In his initial Council meeting, the President distributed material in which he estimated that the "shortfall" would be $7.9 million, increasing the existing deficit by that amount unless action was taken (document 35). He acknowledged that his figures were "crude" and "ballpark" ones, and when he asked the VP Finance, who had not prepared these estimates, to comment on the figures, he replied that the "shortfall" would be closer to $6 million (Notes, August 21).
Financial estimates used to frame the budgeting process underwent revision over time and predictions were refined based on new information. In mid-October, the Senior Management Team predicted that MOH funding would increase by two per cent for the next fiscal year and that they would have to figure out how to save $10 million in order to have a balanced budget (Notes, October 17). At a subsequent Finance Committee meeting, the EVP slightly revised these estimates when he reviewed the budget planning assumptions. Based on projected increased salary and non-salary costs and the anticipated increases in MOH funding and income from other sources for the 1992-93 fiscal year, he predicted that the deficit would be $11.4 million if there was no MOH increase and $7.5 million if the increase was two per cent, "after building depreciation" (Notes, November 19).

Financial estimates in the early stages were characterized by considerable uncertainty and in framing the budgeting issues, members of the Senior Team tended to be cautious and conservative. In initial presentations, they gave the "shortfall" numbers, but these did not usually take into account measures that would reduce the shortfall, such as known decreases in interest payments, over-estimates of nursing costs (as revealed by several months of experience), the savings from earlier termination of positions and known increases in revenue from bed differential. They cautioned the Finance Committee that unforeseen expenses, contract settlements or a percentage change in funding could alter the budget outlook. Although they reported the amounts they
anticipated receiving in the coming months for growth and equity funding, they did not initially point out to the Finance Committee that these amounts would improve the outlook, as they would be added to the base budget for the 1992-93 fiscal year (Notes, November 19).

5.1.4 Potential Strategies and Limitations

In the initial discussion of the mid-year revision of the budget, the President framed the budget planning in terms of some solutions by setting out potential strategies and limitations. He told Council members that all departments should calculate six percent reductions for the remainder of the fiscal year in order to achieve a break-even budget (document 35). He then estimated that staff reductions of 160 people and closure of 100 beds would be required and he directed senior managers to assess the impact of such measures. His messages were somewhat mixed. Although he "suspected" that beds would have to close, the President noted that the Board was "truly sensitive" about patient care (Notes, August 21). While he indicated that they should "try not to have layoffs", he also noted that "any personnel or programs not needed [are] to be terminated immediately" (document 35).

The strategy of lobbying the MOH for additional funding did not seem to be considered a viable option as the Ministry had sent signals that there would be no additional funding during the year. The President reported that the Ministry was saying that hospitals had received "ample time" to plan for a balanced budget, so even though the Ministry had provided additional funds for contract
awards in the past, it seemed unlikely this time (Notes, August 21). In addition, the President did not want to risk criticizing the government as MOH approval of a $5 million capital grant for the OR project was pending. He asked: "How can you bite the hand that feeds you?" (Notes, August 21).

When the Senior Management Team first discussed the 1992-93 annual budget, members had differing views on how to approach the problem of reducing expenditures in order to give direction to middle management. The EVP said that one way was to set across the board departmental cuts, although he recognized that there were complaints that this was unfair. The VP Professional Services objected to the idea of across the board cuts as it would "wipe out" some departments and that it would have a domino effect on other ones. Someone suggested that they put together a comprehensive list of activities that could be eliminated and make cuts in non-patient care activities first. The VP Finance suggested that targets should be set for areas and then they should look at inefficiencies. He gave the example of paid hours as a target and said they should look at reducing overtime and use of nursing agencies. They decided to give the challenge to middle management and ask department directors to look at what could be eliminated and manage with four per cent reductions in departmental budgets. Although one VP objected to this approach, they agreed to meet with directors and tell them they wanted feedback in one month's time on the impact of such a reduction (document 129, Notes, October 17). Although they did not identify specific
strategies, one VP predicted, "We'll be closing beds" (Notes, October 17).

5.1.5 Scope of Input.

Senior administrators discussed the scope of input into the allocation process in the initial phase, and while there was an announced interest in widening the scope beyond the senior level, there was also some reluctance to do so. Early in the first Council meeting about budget reallocation, the President stressed the importance of "major" medical staff and employee involvement in putting forward ideas for savings. Later in the meeting however, he emphasized the need for confidentiality of information and documents. When senior physicians asked how they could get medical staff input and maintain confidentiality, the President explained that another week was needed to obtain more information and clarify the budget figures. Once that was done, he wanted to involve staff and hold open forums (Notes, August 21).

In planning the annual budget, a Committee of middle management was established to guide the preparation of budgets by departmental levels. The VP Nursing had told me that physicians were brought into the budget process too late and she would like to see earlier involvement of senior physicians, however no plans were made for this in the initial phase (Notes, September 6). The EVP did say that he would like to get input on the budget in order to find savings and he asked the Team how they might use the Fiscal Advisory Committee (FAC) or how they might get feedback from groups of people drawn from various parts of the hospital. He said that
this seemed important from a communications standpoint, but other members of the team disagreed with this approach as they believed that the Directors of departments would be offended by a process that seemed to bypass them (Notes, November 18).

5.2 Phase 2: Building the Budget Proposal

Once the context for planning was established, senior managers began to build a proposal that could be forwarded to the Board of Trustees for approval. As noted above, some early strategies had been identified in the framing phase and these were further investigated during the building phase. The building phase also overlapped with the third "selling" phase, in that decisions on some final elements of the proposal extended into preparation of the presentations to MAC and the Finance Committee. Although budgeting required a large number of decisions at all levels, only the major components of budget building are described in what follows.

5.2.1 Base Budgeting

In the usual preparation of an operating budget, senior management at Riverview asked departments to submit budgets for the coming fiscal year based on the past year's budget and anticipated changes in the demand for services in the coming year. Submitted budgets had been reviewed by senior management and adjusted as needed to balance the budget (Interview 1, 2 & 3). This budgeting approach had been used in preparing the 1991-92 budget and although the budget was not balanced, it was approved by the Board. The President had initially suggested going back to departments to ask
them to cut six per cent of their operating budgets for the remainder of the fiscal year, but Vice Presidents did not consider across the board cuts to be a feasible approach in the short time available (Notes, August 21). When the EVP returned from summer vacation and resumed leadership of the Senior Management Team, the Team maintained their "budget initiatives" approach of selected operational reviews, elimination of positions, and bed closures (Notes, September 4). Although the President had initially suggested more bed closures and sought to balance the budget, the Senior Management Team advised against this approach. Because they considered that larger bed closures would be "too disruptive" to Riverview's operations, they proposed absorption of a slightly smaller-than-planned deficit (Notes, September 3). The EVP told me that they thought they could handle the deficit this year, but that such a deficit could not continue.

In the annual process of allocating the 1992-93 budget however, the approach of adjustments to the base was used again, "on the assumption that it's [services] all necessary" (Interview 3). Middle managers were asked to reduce expenditures by four per cent and they guided front-line managers accordingly in the development of departmental budgets (Notes, November 21). The EVP told the Finance Committee in November that some directors were reporting that they would be able to handle the reductions while others reported that they would have to reduce services.

In January, the VP Finance reported rumours that departments were not making the four per cent cuts required and were waiting
for a second "go around" of the budget (Note, January 8). According to one VP, this kind of initial budget request was a "ritual" and he had seen it in the previous year's budgeting process:

VP: I mean everyone feels obligated, irrespective of what the rules are, just on the basis there may be an outside chance they might get something, to let you know they need an awful lot more. (Interview 3)

When the figures were compiled, the VP Finance reported that there were increases in all of the divisions, except for his, for an overall increase of 1.3 per cent in the budgets submitted and a $13.1 million "problem" (Notes, February 10).

The Vice-Presidents were asked to go back to their directors to make further cuts in the submitted departmental budgets (Notes, February 10). The VP Professional Services objected to further across the board cuts, but the VP Finance said that four per cent should be the target, even though each department might not end up with this kind of cut. There was reluctance by some VPs to characterize the process as "across the board" cuts and dislike of this approach had been voiced by some senior physicians, Board members and middle managers as it might penalize "efficient" units and did not reward those who maintained balanced budgets (Notes, January 15, 21, 29). Some VPs expressed frustration about making further cuts and wanted the process to be mapped out, with deadline dates and clarity about how decisions would be made on whether an item was "in or out". Two VPs said that they had to have physician involvement in some of the decisions, but the EVP was reluctant to set a date for a joint senior medical/senior management meeting.
until they were "further along". It was agreed that Division figures would be reviewed with assistance from the Finance Department, so that additional cuts would be found (Notes, February 10).

Later, all members of the Senior Management Team reported on further cuts from their divisions, but some decisions, such as hospital bed closures, were still pending and would affect costs in each division. In addition, some decisions on the level of service for clinical activities such as laboratory testing and bone marrow transplantation would have to be discussed in more detail with senior physicians before final budget figures could be established. Although the final figures were not available from the divisions, senior managers thought that further expenditure cuts would be required (Notes, February 17).

Two joint meetings of the Senior Medical and Senior Management Committees were held to address issues relating to clinical services and broader options to reduce expenditures in the budget proposal (Notes March 3 & 8). The VP Finance reported at the beginning of these, that the latest "budget run" showed a $2.5 million deficit as they did not get the costs out as anticipated. Although one physician commented that this was not a large deficit, the VP Finance said that there was a bylaw that the hospital must have a balanced budget and others agreed that the purpose of the meeting was to achieve this balance (document 191).

Senior managers and physicians reviewed items prepared by each division and made decisions that held service volumes in specific
clinical areas to current levels or reduced them somewhat. These items ranged from capping the number of bone marrow transplants at current year levels to reducing the cases handled in the Gastrointestinal Unit. There was agreement to reduce staffing in the Case Room, based on data from the VP Nursing about the decreasing number of deliveries. Given the overruns in bone marrow transplantation in recent years, one proposal was to cap the number of these for the coming year. As the VP Nursing, the Chief of Medicine and and the Chief of Surgery were reluctant to decrease these, they agreed to hold the number at the current level and relook at it, should additional ones be required. Similar decisions were made to maintain the current levels of service in a day unit, peritoneal dialysis and the Intensive Care Unit, with some effort made to find out if other hospitals could provide additional services, if required. Compromise was made on some items, but there was resentment expressed by physicians about nursing management of a day unit and some of the standards imposed by the nursing division, such as those for cleaning scopes, that physicians did not believe were necessary. Other items were identified for further discussion (Notes, March 3).

The joint committee then discussed other options, one of which was a two-week shut-down of elective surgery in the summer, similar to that done at Christmastime. It was noted that a large number of people would have to "buy in" to the proposals and physicians agreed to discuss the potential for this option with medical staff. A proposal to close one OR was discussed, but the Chief of Surgery
said he preferred to identify other ways to save money in the OR first (document 204). In order to find the savings, the OR Committee wanted "to be empowered" to do a number of things, such as driving the negotiation of several medical supplier contracts and conducting a review of drugs used in the OR. It was agreed that the two-week summer shutdown would be discussed at MAC, but no mention would be made of closure of an OR. At the conclusion of the two joint meetings, the VP Finance reported that they were now close to balancing (Notes, March 8).

5.2.2 Hospital Beds

The closure of hospital beds was by far the most contentious component in building an allocation proposal. In both the process of revising the 1991-92 budget and developing a proposal for 1992-93, senior physicians and senior managers were involved in decisions about bed closures, with input from a few middle managers and medical department chiefs. Although most decision-makers seemed to believe that some bed closures were "inevitable," there were debates about the number of beds to close and which beds to close.

The first round of bed closures was proposed during revision of the budget. Riverview had closed 58 beds for the summer period, but there was some confusion about the number of beds that would re-open in the Fall. There had been an intent to keep some of these beds closed as "savings" from closures were assumed in the list of budget initiatives for the year (document 49). When the President first posed the budget problem, he identified the impact
of his estimate of the deficit as closure of 100 beds (Notes, August 21). The first proposal from Senior Management for reallocation of the budget included continued closure of 58 beds which they estimated would, along with other measures, bring the deficit down somewhat to $2.8 million at year end (Notes, August 28).

When the proposal was presented by the EVP to the Council, data on beds by medical department were provided to indicate where "bed savings" could be made if there was a shift to out-patient surgery, conformity to peer-average lengths of stay and an occupancy rate of 92% (document 42). The analysis indicated that 17 to 22 beds could be closed if peer-average lengths of stay were achieved and about 17 additional beds could be closed if the surgical day unit was used more fully to replace in-hospital care. No reference was made to these data during the meeting and comments during discussion suggested that bed closure was a sensitive issue. The EVP said that he would like more time to spend on bed closures so that it would be done in an "appropriate way" to ensure that bed closures would "fall out as the last resort" (Notes, August 28). The VP Medical objected to the proposal to close 58 beds and preferred that they accept a somewhat larger deficit and only close 20 beds at this time. He said:

VP MEDICAL: Therefore, ...we would decrease the service to the community. And there are two spinoffs from that: there is the spinoff from not providing the same level of care to the community and then there is a risk, a real risk, from physicians, uh, of having some unemployed physicians. How much sympathy that generates, I'm not too sure, but that's a risk because if we go on to further bed closures we may continue to keep two operating rooms closed and on top of
that, would be the need for less people. And I think as we develop this and go through the communication process we have to be fully aware of that risk and the whole scenario. (Notes, August 28)

Following this meeting, the proposal was revised and as bed closures were reduced to 20 beds, the deficit figure was revised upwards. The EVP told me that he believed that balancing the budget this year would cause too much "disruption" and that although the President was "a builder", other people would advise delay in the capital projects. He noted that cutting staff and starting construction was like "being between a rock and a hard place" (Notes, September 4).

The second round of debate with regard to bed closures came during the development of the 1992-93 operating budget. During the Fall, reported and rumoured closures at other hospitals were noted, although there was no mention of bed closures at Riverview's meetings of senior groups (Notes, November 19 & 27). In mid-December however, when the Senior Management Team discussed what they were hearing from directors about the impact of a four per cent cut in department budgets, one VP asked about bed closures as he had heard that a closure of 38 beds was being considered. Although there was no direct answer from other VPs, the VP Medical commented that there had to be a four per cent decrease in full-time equivalent hours to save dollars and the VP Nursing noted that the amount of savings depended on which beds were closed (Notes, December 17).

Prior to January, there was no indication in senior meetings that detailed planning for bed closures was underway. However, it
seemed that at the level of middle management, such planning was taking place. In late January, a middle manager in Nursing told me that they were getting all the departmental budgets in and that they had developed a proposal for beds cuts that considered an earlier request from the Chief of Geriatrics for consolidation of beds into a long term care unit and a request from the Chief of Surgery to combine thoracic and respiratory beds into one unit. She thought that some of the surgical areas that would be shifted would not be too happy with the plans as four surgical units would be reduced to three (January 27/91).

The day following the Premier's announcement of a one per cent increase in funding for hospitals, the President held a series of "open forums" for staff. At a forum for hospital managers, the President told them that "your--our jobs at this hospital are quite secure" and although there was "no 100% guarantee," they were not planning any bed closures, program cuts or service reductions (Notes, January 22). He said that the goals were: to preserve high quality patient care, to preserve levels of community service/volume (mentioning that patient beds were not important anymore as a measure of service) and to preserve the jobs of everyone, despite the fact that they would have to save about $7 million in order to balance the budget.

This optimistic presentation greatly distressed the Senior Management Team and senior physicians--the senior managers because bed closures were being planned and the senior physicians because they thought that the President presented a picture of the status
quo. When criticized by senior physicians for not making reference to the new mission statement and the strategic planning process, the President said that his approach was that the main concern of these people was their job security and he wanted to provide a "modest degree of reassurance" to them. At another open forum for staff later that day, the President was slightly more cautious, saying that they weren't 100% sure and it would be some time before they had a better understanding of the finances, but that "we think jobs are quite secure" (Notes, January 22).

Amid concerns about "medical buy-in" of a bed closure proposal, the VP Nursing reported that middle managers had identified 30 beds that could be closed on the basis of low utilization and a possible additional 30 beds if there was reorganization to consolidate proposed units (Notes, January 27, February 4). The VP Medical was concerned that the second 30 beds would be a problem and that the first 30 beds "haven't been to medical staff either" (Notes, February 4). There was some debate about what the forum should be for discussion of bed closures, and it was agreed that the Senior Medical Committee should approve the work of a group that had developed a proposal. The President advised that the Board would not approve a budget without knowing what impact such reductions would have on the community and if planned closures in other local hospitals would affect Riverview (Notes, January 27).

At a Senior Medical Committee meeting, a Nursing Director and the Admitting Director proposed that 30 beds could be closed based
on "logical statistics" and that an additional 13 beds could be closed based on guesses about reconfiguration of beds. When asked by the Chief of Medicine about criteria used to build the proposal, they replied that they had looked at LOS data from 1990-91 from the HMRI, moved the occupancy rate to 91% (which they said was considered to be "comfortable" with minimal OR cancellations), included a long term care unit with the assumption that all clinical services would participate, combined similar disciplines in units, and considered the move from in-patient to outpatient services based on surgical day care and ambulatory care. The Chief of Medicine thought that consistency with the mission statement and the strategic plan "to date" should also be a criterion and that while the proposal addressed efficiency, he thought that the next step was strategic planning. The Chief of Staff added that integrity of units was important as education of nursing staff was required when they were moved to new units (Notes, February 11).

The Chief of Surgery and the Chief of Medicine asked if all services were on the list for consideration in developing the proposal. The presenters said that they did not include one that was "efficient" (the Clinical Centre) and they believed that geriatrics and medical oncology were "protected" as they had been last year. They reported that if you adjusted the Clinical Centre beds, it would be upwards, based on efficiency and occupancy. The EVP confirmed that there could be no closures in the Clinical Centre or psychiatry without consulting the Ministry. The physicians asked why some areas like plastic surgery and vascular
surgery were not on the list and were told that they did not consider putting one or two beds "off service" on a unit, but that the proposal could be reworked in this way if such direction was given (Notes, February 11).

The Chief of Surgery thought that more time was needed to do things properly and perhaps more than 43 bed cuts were needed as well as consideration of a three year plan. He expressed frustration at having "quick meetings for quick fixes" and objected to doing things at the last minute, saying: "This place runs by crisis management" (Notes, February 11). He argued that they should take a longer term view and perhaps rework the proposal to look at more beds. The EVP resisted further bed closures saying that they were the "easy way out". He agreed that a forum for longer term planning was needed, but both he and the VP Nursing emphasized that there was an urgent need to decide on bed closures as the budget had to be ready for the Finance Committee in several weeks time. The VP Nursing said that senior management wanted to have a joint meeting with the Senior Medical Committee, but the Chief of Medicine replied that they had been "saying that for two years". It was agreed that a committee, consisting of the Nursing Director, the Admissions Director, the Chief of Surgery, the Chief of Medicine, the VP Nursing and perhaps some others, would meet to examine the proposal and come up with one for the next Senior Medical Committee meeting (Notes, February 11). It was reported that plans were progressing for the same day admission unit, but that they might not make the target date of April 1 (Notes,
Over the next weeks, there were rumours that a clinical program was contemplating bed cuts in order to save money. The VP Nursing also reported that more closures might be required as the Nursing Division was short of its target for savings. The VP Medical said that some senior physicians were trying to negotiate for other resources, such as additional CT scanners, in exchange for an agreement on bed closures and he emphasized that the 43 proposed bed closures were contingent on the same day admission unit "period". The EVP said that he did not want to see closures "extended beyond 43 beds" and that he would clarify these matters, in writing, to the Chiefs of Medicine and Surgery. The date for bed closures was debated as the VP Nursing pointed out that it took time to reorganize the nursing units and transfer nurses. The VP Medical thought that it made more sense to do the closures in June with the summer closures, but the VP Finance was concerned that they would lose the benefit of a full year's savings if they waited that long and he suggested a compromise date of May 1 (Notes, February 17).

A bed allocation proposal was discussed by a group of middle and senior level physicians and nurses and several changes were made to the original proposal. The Division of Surgery did not agree to participate in the long term care unit, so a decision was made to combine Family Medicine and long term care beds in one unit. Nursing was concerned that this proposal reduced savings, as a higher percentage of Registered Nurses than planned would be
required for Family Medicine patients. There was some suggestion that the Chief of Surgery was having difficulty getting agreement to the proposal from his department heads, as staff members had seen him in "arguing in the halls" with surgeons on two occasions (Notes, February 20). When the proposal was discussed at the next Senior Medical Committee, the Chief of Surgery reported objections from his Division that waiting lists would increase, two surgical services already had difficulty getting access to day surgery, on one unit offices would be separated from patient care beds and costs for relocation of equipment would be expensive (document 185). The Division thought that everyone, including the Board, should be aware that services would decrease. It was agreed to rework the proposal to bring the number of beds to be closed back to 43 (document 185). Nursing was working out the budget of the altered proposal, but they did not believe that it was sufficient in terms of savings as they also had to include the costs of the new same day admission unit (Notes, February 20).

At a Senior Management meeting, there were reports that the bed allocation group had met and worked out some compromises, albeit with continuing concerns from Surgery about the geographic relocation of some services (Notes, February 24). At a Senior Medical Committee meeting a few days later, despite concerns expressed by the Chief of Surgery and Chief of Medicine about reduced services and integrity of services, one moved and the other seconded a motion for acceptance of a bed allocation proposal that reduced beds by 43 (document 188). In a discussion of the budget
process with a Nursing Director, she told me that they now had to find more nursing cuts in order to balance as they "lost" savings with the reworking of the bed allocation proposal. She thought that they may have to look at closing more beds or closing one OR, but that she had to guess what the savings of closing an OR would be as "we have no costing data" (February 26).

The potential for further bed closures, beyond those already approved at the Senior Medical Committee, was discussed in several meetings, particularly as the budget numbers were compiled and further savings were required. At a joint meeting of senior medical and senior management committees, the President asked "Why not get rid of psychiatry?". He was told that psychiatry was "protected" and that when another hospital tried to close psychiatric beds, the Ministry would not allow it (Notes, March 3). The next day, a senior physician reported that another local hospital was closing psychiatric beds, and according to his contacts, those beds were not "protected". The President agreed and talked to the EVP about looking at psychiatry. The EVP said that while psychiatry was not necessarily "untouchable," closures would have to be discussed with the Ministry, given the historic vulnerability of psychiatric units. The Chief of Surgery said that cuts in psychiatry should be on the same basis as those in other units and that his service was only one day over peer LOS figures, while that for psychiatry was much greater (Notes, March 4). The EVP agreed to discuss the issue of psychiatry further with the VP Medical (Notes, March 4).
5.2.3 The Salary Budget

Personnel costs accounted for approximately 70 per cent of the operating costs and increases in costs were largely due to increases in salary costs (Notes, August 28; Interview 2; January 20, 21). As part of their budget initiatives for 1990-91, the Senior Management Team had identified a list of 40 positions that "we thought that we could downsize or else that in this environment that we couldn't support" (Interview 4). These positions were considered "desirable, but non essentials" and included staff positions in such departments as planning, marketing, internal audit and the parking garage and management personnel in such departments as nursing, physical plant, laboratory medicine and finance (Interview 3).

When the President called for a revision of the budget in August, he roughly estimated that 160 hospital position reductions would be required to eliminate the deficit (document 36). He later modified this to 100 positions beyond the 40 identified positions and noted that, "to the greatest extent possible", staff reductions should be in non-direct patient care areas with the order for consideration to be administration, consulting, staff departments, support departments and then, direct patient care positions (document 37). It was estimated that the salary budget could be reduced by $2 million in the subsequent fiscal year if the 40 positions identified by the Senior Team could be eliminated. However, as these were non-union positions rather than layoffs, some payouts would be required in the current fiscal year (Notes,
August 21, September 4). The Senior Management Team did not seem to think that attrition and retirements would enable the avoidance of lay-offs as the President hoped, as these "non-layoff" considerations had already been factored into the existing budget initiatives (Notes, August 21, 26 & 28).

Senior administrators did not look forward to the prospect of terminating positions or laying off staff. The President said that layoffs were "disruptive and painful to individuals and families" and later worried that if the government did come through with additional funds, they would have "ruined 40 families" (Notes, August 26 & 28). There was also a belief that layoffs and terminations would generate Board member concern about service levels and the inclusion of a few positions among the 40 that had been created at the direction of the Board. In addition, Board, hospital staff and public animosity might be aroused if job loss was linked to spending on capital projects (Notes, August 26 & 28). The Senior Management Team finalized a proposal that would require termination of 40 positions over the remainder of the fiscal year, but as only 20 bed closures were planned, it did not seem that layoffs of unionized staff would be required (document 43).

As anticipated, reduction of the salary budget was a continuing concern when senior administrators began plans for the 1992-93 fiscal year. In discussion at a retreat, the Senior Management Team debated approaches to reducing the salary budget and one VP commented that they needed "younger nursing staff" if they were to control hours and rates of pay. The VP Professional
Services said that such an approach amounted to "age discrimination" and the VP Medical questioned: "Do you want inexperienced staff?" (Notes, October 17). The Team agreed to begin the planning process by giving direction to middle managers to look at the impact of four per cent cuts, but they did not discuss the potential impact of such a cut on employee positions.

Due to the protracted planning for departmental budgets and hospital bed closures, the impact on employees was not known for some time. At a January meeting, the EVP commented that they no longer expected "massive layoffs," although it was noted that the next two or three years would be difficult (Notes, January 20). At a Finance Committee meeting, the EVP said that as about one-third of the nursing staff was part time or casual, he did not foresee a major layoff of full time staff. The VP Nursing noted that staff turnover was still significant and made staff reductions "less painful" (Notes, January 21). The President reported that anxiety levels in the hospital were high and that he was going to hold open forums for staff following the Premier's scheduled announcement. Later in that evening, after the announcement of a one per cent increase in funding, the President outlined what he would say the next day at the open forums, noting that he had received some advice on this from union groups earlier in the day (Notes, January 21). As mentioned earlier, the President's remarks were considered "too positive" by senior managers and senior physicians.

Despite the President's comments, some employees anticipated job losses. When the EVP and the VP Nursing met with the Fiscal
Advisory Committee several days later, employee representatives reported that apprehension was high among staff and there were rumours about which units would close (Notes, January 24). The EVP outlined the budget problem and said that although he could not comment on positions, people who left wouldn't be replaced and that "obviously, it will impact on casuals and part time". When one employee said that it was difficult to plan departmental budgets without knowing about bed closures, the VP Nursing said that bed closures could not be determined until decisions were made on a proposal for a long term care unit. Following a discussion on how suggestions for reductions could be made by employees, one representative asked if there would be rewards to departments that cut their budgets, even if it was only a letter on file. Another employee representative answered grimly: "You get to keep your employees" (Notes, January 24).

In the midst of budget planning, the issue of executive compensation arose when a Board member asked about the global amount in the budget for executive salaries and brought motions to an "in-camera" session of the January Board meeting on making executive salaries public (January 30; document 183). In December, reports of a high salary to a debt-ridden hospital's President had been in the media and the Board member made reference to this story in justifying his questions. The Board agreed to obtain information on executive compensation for the next Board meeting. Traditionally, executive compensation was not discussed at a full Board meeting, but rather decisions had been made by a smaller
"compensation committee" of the Board (Notes, February 10). The President told senior managers that he was uncomfortable with this development and while senior managers had varying views on what could be done, most expected that there would be "leaks" on their salaries to the media. The President believed that he was the target of the Board member's interest in disclosure of executive salaries and perks, but all of the VPs viewed developments as an indication of the Board's distrust of senior management.

In mid-February, the President informed the Senior Management Team that he had talked to the Chairman of the Board and they had agreed that executive salaries would be frozen (Notes, February 17). He also reported on complaints about how the hospital operated from several Board members. In the following days, although the issue was not discussed in formal meetings, a VP told me that some senior managers were angry, were thinking about quitting and did not think that they were getting support from the Board (Notes, February 18, 26, 27). Senior managers expected their salaries to be "all over the paper" the next day, but Board members voted to keep salaries confidential before reviewing the actual salary figures and two dissenting Board members left the meeting (Notes, February 28). The Board did agree to write to the Ministry to request that hospitals in the province make executive compensation public, but they did not believe that they should do so until all hospitals engaged in this "open" policy.

Beyond layoffs from bed closures, Senior Team members considered other approaches to reducing the salary budget, should
additional cuts be needed. The approach of asking employees to take a salary reduction was raised in December, but VPs did not think such an approach was likely to be successful (Notes, December 17, January 21). In February, the VP Finance included an approach to the nurses' union about reductions on a list of measures that might constitute a "fallback position," (Notes, February 4). Later, when a joint committee of senior management and senior physicians worked to make the last cuts, a physician asked if they could reduce the negotiated rate of the nurses union contract. The VP Personnel said that the union had been approached on this, but had refused (Notes, March 3).

The possibility of imposing a wage freeze for non-unionized staff had been mentioned earlier as a potential strategy, but most senior managers thought that this would be unfair (Notes, December 17, January 20). At a Finance Committee meeting, a Board member questioned if non-union staff might take a voluntary freeze "rather than turfing out the weakest," but Senior Management told him that they were concerned about the "wage compression," as it would result in senior staff earning as much or more than their managers (Notes, January 21).

When it seemed that they were still far from balancing the budget, a management freeze for those earning more than $40,000 a year was suggested, but senior managers were uneasy with this strategy saying that it would "screw" the management group and even drive them to unionize (Notes, February 4). Later reports of a similar freeze at another hospital did not change anyone's mind and
a VP said that they would be "balancing the budget on the backs of the unprotected" (Notes, February 17). When this option was raised with senior physicians as they searched for the final cuts, physicians were also uncomfortable with this approach, especially if it might lead to unionization of nurse managers (Notes, March 3). Several days later, the EVP said that a decision had not yet been made on a freeze of non-union salaries and the VP Personnel reported that another local hospital had decided to hold the increase to one per cent, but allowed movement on the grid, although most people were already at the top of the grid. Later that day, the EVP told directors that they would be recommending a one per cent increase for non-union staff, but that it would be reviewed in six months and if finances permitted it, they would "move from there" (Notes, March 9).

Other reductions to the salary budget were discussed such as hiring freezes, a freeze on sick bank credits and trimming of the management and support staff ranks (Notes, February 4, February 17, March 3, March 9). A hiring freeze was already in effect, but senior management and physicians noted that it was difficult to enforce "across the board". Contract negotiations would be required to change sick bank credits and "trade-offs" might be possible in the future (Notes, February 4). It was agreed that two VPs would use an identified list of criteria to review possible elimination of additional management personnel and also to examine support personnel positions (Notes, February 17).
5.2.4 The Revenue Budget

The revenue side of Riverview's operating budget was made up of funds from the Ministry of Health and non-MOH sources of revenue. As MOH funding, the largest revenue component, was not under the control of senior decision-makers, most of the discussion about it amounted to rumours and speculation about what the funding would be. Some attention was given by senior groups to how additional revenue might be generated and discussions of these strategies were less contentious and protracted than those about expenditure reduction.

Non-MOH sources of revenue for Riverview included charges for semi-private and private hospital rooms, daily charges for non-Canadian patients, payments for out-of-province and Workers' Compensation patients, parking fees, cafeteria revenue and sales of services to outside organizations. Proposals for the generation of increased revenue were discussed by Senior Management and forwarded to the Finance Committee for recommendation to the Board. In August, the Finance Committee approved an increase in the non-Resident per diem rates so that in planning the revision of the budget, Senior Managers projected an additional revenue of $300K by year end (Notes, August 28; document 75).

The private and semi-private room rates, known as "bed differential," had been increased in 1990-91 and Senior Management had, as part of the 1991-92 budget initiatives, encouraged staff to ensure such revenues increased by facilitating the transfer of patients with insurance coverage to available semi-private and
private rooms. In addition, when beds had been closed for the summer, these closures were somewhat scattered by removing one or more beds from a room that had originally been a ward. Although not intended as a strategy, this practice resulted in increased revenue, as many of the patients occupying those rooms had insurance coverage (Interview 5; Notes, September 4). In reallocating the budget, $150K beyond the "budget initiative" target was added to the revenue estimates for this item. Nurses complained about the number of patient transfers they had to oversee as a result of the push to increase differential income and an insurance company representative complained to Riverview about not being notified of changes in the number of semi-private and private beds, as per their agreement (Notes, January 20 & 24). Nevertheless, this strategy proved to be one of the areas of "largest gain" (Notes, January 21) and in February, the VP Finance told the Finance Committee that they were considering increasing the room rates in the next budget. There seemed to be support for this idea, provided that there had been no complaints about the current rates (Notes, February 18).

Another idea for increasing non-MOH revenues was raising parking rates and eliminating some of the complimentary parking (Notes, October 17). Although senior managers thought this was feasible, parking rates were traditionally a sensitive issue, and parking had turned out to be a political issue with the hospital's neighbourhood group in the Fall (Notes, October 9). For that reason, the EVP said he would first discuss parking with "certain
interested individuals" before presenting a proposal on parking rates (Notes, November 25). Increased parking rates were included in revenue projections for 1992-93, although senior managers were reluctant to end complimentary parking passes for patients coming in for dialysis, especially since another local hospital provided such passes (Notes, March 13). When a VP mentioned at the Fiscal Advisory Committee that parking rates would be increased, an employee representative objected to these and commented that "you are looking at parking increases" when there were a lot of rumours around about "top people's salaries" (Notes, March 16).

The VP Finance was also making efforts to "manage the balance sheet". These efforts were particularly noticed by Board members on the Finance Committee who had a background in business, and one Board member commented favourably on the reduction of accounts receivable (Notes, January 21). The VP Finance reported that he was trying to collect unpaid bills from non-residents. When the VP Medical said that in the past, there was a policy of not pursuing patient debts, the Finance Committee indicated that it was willing to change the policy, if one existed, and supported efforts to collect such debts (Notes, December 17). There were limits to this however, as when questions were raised at a senior management meeting about a foreign patient with no remaining insurance who was receiving dialysis, the decision was that the hospital and physicians "had no choice" but to treat him anyway, as he would not be able to receive such treatment if sent back to his country (Notes, January 20).
Budget building proceeded in the absence of certainty about MOH funding. The 1991-92 budget was revised in September 1991 and the confirmation letter from the Ministry that no additional funds would be provided arrived in late October (document 121). In that letter, the Minister advised that "growth, equity and life support funds will be allocated in November" and that there would be no further funds for the year. The Minister also wrote:

There is no question that we will be experiencing substantially lower growth rates over the next two to three years, necessitating a longer-term approach to management of limited resources. (document 121)

Uncertainties about increases in the base amount for 1992-93 and equity and growth amounts that Riverview might receive for 1991-92 continued until January, although rumours and unofficial reports were repeated at meetings (Notes, October 7 & 23; November 18 & 19, December 16). In December, the EVP told the Finance Committee that he would "stick his neck out" and report a rumour that the $2.5 million cap on equity funding might be raised, but there was some suggestion that growth funding might not be received (Notes, December 17).

Some of the uncertainty was reduced when the Premier announced a one per cent increase in transfer payments to hospitals for the coming year, followed by two years of two per cent each. Senior managers estimated that they were now dealing with a $6.6 million "problem" (Notes, January 21). Although senior groups were generally pleased, there was some caution as they wondered if the details of the one per cent announcement may turn out to mean less than that for individual hospitals. When uncertainties about equity and growth funding continued, the EVP resisted physician
demands for a longer planning time frame for decisions about bed closures saying that they were dealing with "a lot of soft numbers," such as equity funding (Notes, February 11). At a Senior Management meeting, the EVP commented on receiving a "windfall" in equity funding the previous week (Notes, February 17). This was clarified at the next day's Finance Committee meeting, when he reported that they had just received word that they would receive $3.6 million in equity funding, amounting to $1.1 million more than anticipated. The VP Finance said that the money was already spent as he would be paying down the loan with it (Notes, February 18).

As senior administrators and physicians worked to make the final cuts of $2.5 million to the expenditure budget, the VP Finance described the plan as being "stretched on revenue" because it depending on getting non-MOH funds (Notes, March 3). The first hint in meetings that news on growth funding had been received, was a reference during the last days of budget planning that an additional $2.2 million had been received for equity and growth, suggesting that $1.1 million was received under the revised growth funding formula (Notes, March 13). Later, the EVP reported to the Finance Committee that nothing had been expected for growth funding, so that when combined with equity funding, $2.2 million "falls into the base for next year" (Notes, March 17).

5.2.5 Special Purpose Funds

Although much of the focus in developing operating budget proposals was on funding regular "base" services at Riverview, there was also pressure to find enough flexibility in the budget to accommodate funds for special purposes and for investment in new
directions for the future. Some proposals for one-time funds arose during the budgeting process, but the more difficult challenge for senior management were those special purpose funds that constituted a continuing commitment by Riverview that had to be offset by a reduction of activities in other aspects of the hospital operation.

A special purpose allocation had been made in 1989-90, when the Board had directed that a recruitment fund be established "to attract the very best" physicians to Riverview. This was done when an initial attempt at strategic planning had been made and "four foci" of interest had been identified (Interview 12; documents 30 & 79). The fund, which had been more than $1 million for the past two years, was recorded in the "non-service" portion of the budget book and was under the direction of the Senior Vice President. These funds, as well as funds for depreciation and other non-cash expenses were part of the annual operating budget, but were also a source of confusion for senior management because they were separated out into a "non-service" budget and therefore did not seem to be like "service" operating funds. One VP explained:

It was just...somehow, that pot grew magically or shrunk magically, but it's very confusing for a lot of people who still live and function in that....It's just what [the VP Finance] is trying to drive home. There's only one pot of money and if you say, "Fine, we're going to add $500K to [the Senior VPs] recruitment fund--but that's not operating"--it's got to come from somewhere. (Interview 3)

Budget flexibility was also required to accommodate changes in direction that were emerging in the strategic planning process. There was a clear intent to identify "programs of excellence" towards which Riverview would shift funding, but there were also
suggestions that there should be an increased investment in research (Notes, August 28, September 30). Senior managers seemed to worry about finding the budget flexibility to support the "research imperative". When the EVP presented a proposal for revision of the 1991-92 budget to VPs, he remarked that although the President had told him that they had been able to absorb a deficit several years ago, he had pointed out to the President that there was no Research Centre then, which "takes operating money" (Notes, September 3). In October, the VP Finance commented that he was "deathly afraid" of the impact of the capital expansion of the Research Centre on operating expenses (Notes, October 17). When the President presented a three-year business plan for Riverview to senior managers, this concern about shifts in funding was raised by several VPs and one wanted some discussion of how much operating money should be allocated to the research, education and service mandates of Riverview. When the VP Finance asked how planned increases in the staffing of the Research Centre would be funded, the President said that the money came "from research [grants] and other sources" (Notes, January 27).

A major source of pressure in keeping the operating budget under control was the allocation of substantial amounts in the previous several years, under the "non-service" component, to the development of computerized information system projects (document 79). Although these items had been "sold" on the basis of future savings, such savings never materialized and senior managers were concerned about how to accommodate such "projects" and others in
the capital plan (Notes, October 2, September 23/92). The pressure increased when the President reported to them that the Board was concerned about stories of deficits and financial problems from other hospitals in the province. He told them they were also concerned about the OR project and emphasized the need to "preserve enough dollars with operations for this" (Notes, December 1-2).

The Senior Management Team seemed to have their own project, that of establishing a "transition fund" to provide payouts to those whose positions were eliminated or to provide education and retraining for those employees who might be shifted to another position when their jobs were eliminated. In early March, the EVP and VP Personnel noted that payouts and retraining would be required with positions eliminated (March 3 & 8) and the EVP told me that he would rather spend money for "staff training and transition" than on a heliport (March 9). He told Directors that equity money may be put into a transition fund and they might not be able to rely on such funding next year. The first formal mention of the transition fund occurred when presentation of the budget proposal was discussed at a senior management meeting (Notes, March 13). The EVP said that a decision had been made to set aside a transition fund for staff and implied that they would use unexpected growth and equity funding for this purpose.

Changes in funding arrangements for the Clinical Centre were another source of uncertainty for senior managers in planning for the 1992-93 operating budget. Although the Clinical Centre was considered by the MOH to be part of Riverview, because of its
specialized services and regional mandate there were direct discussions between the Centre and the MOH regarding funding for special procedures and specified volumes of these each year (Notes, February 18 & 24). Agreements between senior administration and the Clinical Centre with regard to funding allocations also existed, but there were indications that the Director of the Centre wanted to change these agreements so that the Centre received out-of-province income directly. He believed that Riverview benefited financially from Centre services, especially through equity funding that the Centre generated, and that the Centre was not adequately compensated for that benefit (Notes, November 19, January 21). During budget planning for 1992-93, there were reports that the Centre might be having difficulty balancing as they were not doing the volume of cases for which they had budgeted, although the EVP reported that the Centre was committed to balancing their budget for the coming year (Notes, February 4, 10, 17, 18 & 24). At the request of the Director, the Executive Committee of the Board met with him to discuss financial and other matters and at that meeting he began by giving a presentation on the success of the Centre in service and teaching. He said that he believed the out-of-province revenue issue could be worked out, and the EVP agreed. He referred to the Centre's contribution in bringing Riverview equity funds and said that although there was "some talk" about doing a detailed breakdown of overhead expenses that Riverview carried on behalf of the Centre, he thought that this would be unnecessary and "distruptive". He said that such "number-crunching" was possible,
noting that there was "a perception at the Ministry" that the Centre was contributing too much to Riverview's core budget. However, in his view, such an analysis would "divide" the hospital (Notes, March 11). The Director characterized the issue as a "sensitive" one and the EVP termed it was one "of fairness".

The budget proposal for 1992-93 included an item in the Centre's budget of $1.4 million as an amount "required to balance". When senior managers expressed concern about the line item for "other projects" in the budget book, the VP Finance said that it was an unidentified reserve or a cushion (Notes, March 16). He later clarified that "other projects" and "board contingency" totalled close to $1.4 million which would keep them out of trouble if the Clinical Centre could not balance.

One of the ways in which the VP Finance sought to create some flexibility was to pay off the existing loan and therefore reduce, and eventually eliminate, interest payments. During the period of field work, he made frequent references to his wish to "pay off the loan" and from time to time he would report on payments made (Notes, September 3, November 19, January 8, February 18). He resisted suggestions of borrowing money to proceed with capital projects and insisted that if they balanced the budget, sufficient funds would be available to carry out the projects (Notes January 8, April 29). By the end of the fiscal year, the audited financial statements showed that the loan had been eliminated (document 241).

5.3 Phase 3: Selling the Budget Proposal

Although senior managers directed the building of the budget
plan and generated proposals for various components of that plan, they also knew that they would need the support of senior physicians in order to secure Board approval and to successfully implement the plan. Once they had secured approval from the Senior Medical Committee and the MAC, senior management focused their attention on presentations to the Finance Committee and Board members. The "selling" phase began during the process of building the plan, intensified as a proposal was finalized and sometimes continued after Board approval of the budget.

5.3.1 Medical Agreement

As described earlier, senior physicians were involved in several aspects of the building phase. During revision of the 1990-91 plan, they participated early as members of the Council, and in these discussions, the President and Senior Management sought support from them for shifting surgical cases from inpatient to day surgery. In anticipation of bed closures, the VP Professional Services emphasized the importance of making a commitment to doing things differently through new approaches: initiation of a same-day admission unit (for elective surgery), compulsory use of pre-admission testing, enforcing the use of admission and discharge criteria for surgical day-care, decreasing the length of stay and initiation of medical day care (document 44). She noted that:

And there is [sic] probably others but I think that we have to make a decision whether we are going to do these or not. And I think that is something that we really have to take to heart...things that are not going to happen overnight. We're not just going to be able to edict this so that next week we are automatically going to improve community service and do
things differently. This takes time, effort and commitment and I think as far as [same-day admission, etc.] we haven't yet clearly had commitment in comparison to other large teaching hospitals. (Notes, August 28)

The President agreed that it was the "day of reckoning" for such changes. The Chief of Surgery concurred and supported the need to set deadlines and implement some of the initiatives, but he raised issues of resource requirements to decrease LOS and to ensure that the pre-admission testing was available when needed. Several problems related to these initiatives were discussed and the President said that these "roadblocks" had to be removed. When the VP Medical cautioned that there were costs associated with some of the proposed initiatives, the President replied that "you may trade [initiatives] off against bed closures."

When the Senior Management Team discussed a revised proposal with a reduced number of bed closures and changes related to elective surgery, most VPs were supportive of the approach, but cautioned that physician cooperation was required (Notes, September 3). The VP Nursing noted that the new initiatives would have to be monitored to see that they were indeed working, that physicians trusted the process and that savings were generated. Participants identified the need to work with physicians to make pre-admission testing compulsory and to change criteria for day surgery, which were reportedly "conservative". When asked for the probable reaction of medical staff, the Acting Chief of Staff said that he thought the proposal would be accepted well, especially the elimination of management positions, as the perception was that beds were always cut rather than management.
When the Council met to finalize a revised 1991-92 budget proposal for presentation to the Board, the President emphasized the need to "sell" the plan and have it approved by the MAC, the medical staff and the Board of Trustees (Notes, September 4). He anticipated that the Board would ask if the medical staff had seen the plan and if MAC had approved it. He wanted to be able to tell the Board that everyone had "bought in" so that redevelopment could move forward and he noted that although they would not balance this year, the VP Finance would show them that the impact on the cash situation would not prevent them from moving forward. Just before the meeting, the EVP had told me that the President had asked that the goal of capital redevelopment be added to the three budgeting principles. He included this goal in his presentation to the Council and explained that this proposal did not provide a balanced budget for the current fiscal year, because the impact would be "so enormous," "significant" and "overwhelming" and they wanted to maintain service levels (Notes, September 4).

The President asked the VP Finance to discuss the impact of a current year deficit on the redevelopment projects and he explained that because capital spending had been delayed, they would be able to absorb the deficit and proceed with the delayed schedule. He did caution however, that they would have to balance in subsequent years, in order to have sufficient cash flow for the planned projects. The Chief of Surgery expressed concern that accepting a deficit this year might jeopardize the future of capital projects and that increasing the debt load with a deficit might compound
problems for the future. He was particularly worried about the possibility that more capital money would be needed than was currently estimated. In answer to questions about the impact of the deficit on capital projects, the VP Finance continued to emphasize the importance of not having continuing deficits.

The President said that he was "quite reassured" regarding the availability of funds to proceed with projects and asked if everyone was satisfied with the latest proposal. The VP Medical said that "from a medical point of view, the 20 beds were never stated as being a permanent closure" and the Chief of Surgery again cautioned that resources would be required for the elective surgery changes as, for example, some patients could not have day surgery if as outpatients, they had to wait six weeks for a CT scan.

The President asked the EVP to make a motion supporting the plan and then said he "would appreciate it if someone from the medical staff would feel comfortable to second" the motion. The physicians were reluctant to do so, as they wanted to bring the proposal to their colleagues for discussion. It was agreed that the minutes would note that there was consensus on the proposal and it was later approved at a MAC meeting (Notes, September 4 & 18).

When it was decided later that a presentation would also be made at an upcoming quarterly meeting of the medical staff, one VP advised the EVP to say that the proposal "doesn't impact clinical" and the Interim Chief of Staff altered this somewhat, advising that he should say that "the impact was distributed," so that "not just" clinical was affected (Notes, September 18).
As described earlier, senior physician involvement in building the 1992-93 allocation plan was focused on making decisions about the number and type of beds to be closed, advice on service levels in specific areas, marginal cuts in services and some hospital-wide options. Senior managers and physicians anticipated that there would be some difficulty getting agreement on the bed allocation proposal at the Medical Advisory Committee, but time was running short to finalize a budget proposal for the Board. The Chief of Staff asked for advice on how he should handle the bed cuts at the meeting and asked others if they thought it would be approved. The Chief of Surgery advised that it would not be unanimous as several surgical departments would be opposed. The VP Nursing advised him to focus first on the number of beds to be cut, and to deal with reassignment of beds secondly, as a remix of the beds could be done later, as long as it was completed by March 23 (Notes, March 4).

When the bed allocation proposal was presented at the Medical Advisory Committee, many heads of medical departments criticized the proposal, with one representative from the Division of Medicine complaining that Medicine was "taking the brunt". A department head believed that such changes should be compensated for by an increase in ambulatory care facilities, as this was an area of deficiency noted by accreditors of the medical education program. Several patient care concerns were also raised: in one medical unit, patients undergoing investigations would have to share a room with those who were terminally ill, changing the structure of a unit might affect the infection rate for patients receiving
peritoneal dialysis and "fragmentation" of nursing staff in a unit might occur and patients required nursing support. In a reference to the difficulties of "bumping" rules, the VP Nursing said that every effort would be made to move nursing staff with the patients, although there were some "union realities" to deal with (Notes, March 9).

During the meeting someone mentioned that the bed allocation might have to be readjusted again when the strategic plan was established. The ongoing strategic planning and city-wide discussions of rationalization of hospital services had generated anxiety about the future among physicians (Notes, March 8). A department head mentioned "rumours of a three-pronged effort" and asked if they were "not being shown the whole picture", if there were documents of a larger plan somewhere and if a plan existed to cut another 40 beds. He was told by the EVP and the Chief of Staff that there was no such document or plan (Notes, March 9).

Most of the objections to the bed reallocation proposal were focused on relocation of units rather than the decrease in the number of beds, with a complaint that "some people weren't at the table" when decisions were made. The Chief of Staff asked for a motion on the closures, recognizing "that there may still be changes" on the reallocation of remaining beds. After a silence, the Chief of Surgery said that although nobody wanted to close beds, he would make the motion. When the motion was carried, the Chief of Staff said that they would bring a reallocation proposal to the next meeting, although they were "not going to end up with
something that makes everybody happy" (Notes, March 9).

Approval by the Medical Advisory Committee on the number of bed closures allowed the Senior Management Team to finalize a budget for presentation to the Finance Committee on schedule. However, securing subsequent agreement on the mix and relocation of beds took several more weeks, with competing proposals being generated by both the Division of Medicine and the Division of Surgery (document 215; Notes, April 2). Debate on a new proposal was protracted and the Medical Advisory Committee empowered the Senior Medical Committee to make the decision. A reworked proposal forwarded by the Division of Medicine was subsequently approved, but it required a tie-breaking vote by the Chief of Staff. The Chief of Surgery accused the Chief of Staff of partiality and according to one VP, other members of the Committee were shocked by this accusation (Notes, April 2). The minutes of the meeting noted that the Chief of Staff agreed that there might be a perception of bias as he was a member of the Division of Medicine, but he denied the charge of partiality in his vote. The minutes also noted that other members of the Committee did not support the Chief of Surgery's view (document 215).

5.3.2. Board Approval.

Once senior administrators felt comfortable about "physician buy-in" of proposals, preparations were made to present proposals to the Finance Committee. Finance Committee agreement did not ensure that the Board would approve every item, but without Finance Committee support, the proposal would not be accepted. Therefore,
considerable care and attention was given to known concerns of the Board and time was given to presentation of budget proposals. In preparing for Finance Committee and Board meetings, senior administrators sometimes "tested the waters" and always conducted rehearsals of their presentations.

In the early Fall, the President tested the budget revision proposal by bringing it to a meeting of the Executive Committee of the Board (Notes, September 6). The EVP introduced the proposal by presenting four goals, one of which was the redevelopment goal that the President had asked him to include. He pointed out that the deficit was less than the original deficit figure approved by the Board and that the impact of balancing the budget this year would be "so disastrous" that instead, they were putting initiatives in place that would enable them to balance in the subsequent year. When asked about capital projects, the President explained that the proposed revised deficit would still allow projects to proceed, as capital spending had been delayed. He reported that the Senior Team would balance next year's budget and all of the projects would be able to move forward without exceeding the approved borrowing limit.

In response to the proposal, a Board member asked for more detailed information: "Just give me a general picture of these 40 people who are going to be axed in order to permit us to build" and referred to them as "sacrificial lambs". When detail was provided about the positions to be eliminated, Board members reacted to removal of internal audit staff as this department had been
established a couple of years earlier at the initiative of the Board. The President responded, saying: "Times are tough, people. Gotta focus on patient care".

Discussion then focused on the tradeoffs between the capital and operating budgets:

BOARD: Can I ask a question? And maybe you can give me an answer, which is sort of..set my thinking straight. All of this is being done to balance the budget so we can go ahead with our capital budget.

PRESIDENT: That is right. That is absolutely right.

BOARD: Then we have to analyze why the capital budget is so important that we have to cut all the other items.

PRESIDENT: Well, the operating room is the highest priority.

BOARD: Well you got no argument there.

PRESIDENT: I mean, I can go into that over the next two or three weeks before we..what [the EVP] is doing is giving information today. There is no motion coming out of this meeting--this is simply for an overview. We'll be presenting this to the Finance Committee in a couple of weeks. There's a lot of discussion we will have to have with other people in the institution, with other trustees here today and we'll come back to you with that, with that explanation. Absolutely. (Notes, September 6)

Following continued discussion about capital financing problems, the Chairman of the Board intervened and pointed out that the presentation was really only for information at this stage. The goal of capital redevelopment never reappeared in any subsequent presentations on the operating budget.

In rehearsing the presentation for the Finance Committee, the EVP reported on some of the reaction and "sensitivities" of members of the Executive Committee with regard to elimination of positions, particularly positions in audit and language services. Senior
managers thought that there might be a compromise required on the audit department positions. The VP External Relations emphasized that the message of the presentation should be that "we needed to balance the budget" and that it was "not for capital" (Notes, September 9).

At the Finance Committee meeting, a document was presented that included three goals and described the current year as a "transition" one in which strategies would be employed such as, productivity increases, utilization improvement and organization restructuring. Phase I involved bed closures and expense reductions while Phase 2, in the next year, required elective surgery changes, drug and supply expense reduction, salary budget reductions and implementation of a program management structure. The areas of savings and revenue additions were identified to provide a "financial reforecast" that resulted in a year-end deficit of $3.3 million (document 90). The Finance Committee accepted this information, but no vote was taken (document 75).

Prior to the Board meeting, senior managers anticipated questions on "sensitive" issues and practiced their responses to questions about cuts in these areas, making comparisons with other hospitals on some position cuts (Notes, September 23). They wondered aloud about the reaction of board members, noting that one had supported position elimination in the past when many Board members "hedged" and that another Board member had made many cuts in his position as a CEO. At a monthly Board Preview Meeting, the President reported that the Chairman was "very nervous" about the
authority to close 20 beds. The EVP had reviewed the minutes of the April 1991 meeting of the Board and had found an item related to closing beds. According to the minutes, in discussion of that budget proposal, the EVP had advised: "we are also looking at a permanent bed closure of approximately 20-25 beds, and utilizing out-patient services more effectively" (document 263). The EVP said that the numbers had become confused since that time and the Vice President, Medical agreed and believed that the authority was still not too clear (Notes, September 24).

They reviewed the positions to be eliminated and the EVP put up an overhead slide that listed 40 positions, noting however that only 17 individuals would actually lose a job. When they came to the positions in internal audit, the President asked if they really wanted to leave a one-person department. The VPs didn't respond immediately, and then said that it was the Board who had directed that such a department be established. The President said he was going to recommend eliminating the whole department. There was agreement that someone should talk to two board members who should be warned about the proposed cuts in areas that were of past concern to them, as one Board member would "walk out" if she "heard it cold". At a meeting of the Audit Committee called for that evening, members of that Board Committee agreed to a proposal to dismantle the department if a new position, reporting to the VP Finance, was created. A VP told me that the first time he had heard about closing the department was at the Board briefing meeting. He said that there was a decision to maintain the
internal audit function "for a lot of reasons" and told me that the President had warned another Board member about the other potentially sensitive area and that while she wasn't happy with the cut, she understood the need for it (Interview 3).

At the Board of Trustees meeting, under the Finance Committee report, the President announced that the part on the budget would be "in camera" as staff positions would be discussed. Following the EVP's presentation, there were several questions about internal audit and the EVP explained that they were returning to the one-person staffing of one year ago. When asked, members of the Audit Committee reluctantly supported the proposal. The Chairman asked about settlement packages and when people would be notified. The President asked that information be kept confidential. The climate for this discussion was subdued and a motion to reduce the salary budget was carried (Notes, September 26).

Most of the components for the 1992-93 budget proposal were ready when senior managers began rehearsing the presentation just before the Finance Committee meeting (Notes, March 13, March 16). Rehearsal for the Finance Committee and Board meetings was designed to anticipate questions, structure the proposal presentation, identify sensitive areas and ensure that everyone was prepared to answer questions. Senior managers engaged in role-playing, with individuals acting like Board members and posing questions while others formulated answers. The EVP cautioned senior managers to "avoid fighting" and contradicting each other, and the VP Finance emphasized that it was important that this did not happen at the
presentation. Everyone was to be prepared to answer questions about layoffs and service volumes for their divisions, taking care not to contradict the detailed content in the budget book (Notes, March 13). As little time would be available for the presentation at the Finance Committee meeting, the VP Finance said that he could only provide highlights of savings and a broad overview of the proposal. In addition, senior managers were aware of Board dissension over the failure to reappoint some members for a second term. There was caution that Board members not be rushed as they were "pissed off with everyone" these days and were not going to let anyone "push them" (Notes, March 13).

One sensitive area was layoffs and they decided to present these by divisions, putting in the added staffing for the pre-admission unit to offset the layoffs in nursing due to bed closures. They identified layoffs in pharmacy as "red flag" areas, as there had been a report at the Operations Committee of the Board that identified low staffing as a problem. Based on the reaction to the presentation at the MAC meeting, layoffs in laboratory medicine were also considered "sensitive" ones (Notes, March 13). Several days later, they decided to remove specific mention of pharmacy positions from an overhead slide on layoffs as these were "red flags" (Notes, March 16).

Bed closures and their impact on the level of services to the community were known concerns of Board members, yet the EVP cautioned they had to be careful about saying "maintenance of service" as the physicians objected to this claim (Notes, March
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13). The EVP said he would point out that there was no dramatic drop in patient days while outpatient volumes would increase. The Nursing Director (in the absence of the VP Nursing) said she would give her "usual spiel" about the justification for bed closure, based on statistics. Senior managers anticipated that the Chief of Staff would say something about services being affected as he represented physicians and everyone recognized that he "has his role to play" (Notes, March 13). Later, they decided to add a slide on how they would maintain service levels and arranged the presentation on statistics to show how same day admissions and other measures offset the decrease in patient discharges due to bed closures. When it was noticed that bed closures were not part of the presentation, a participant cautioned: "Don't hedge on that" and they included these on an overhead slide (Notes, March 16).

Several uncertainties were evident during discussion. There was some reference to the Clinical Centre problem in balancing and although the plan did not include an estimated $500K in savings from a two-week shutdown in the summer, this measure was still being considered. There was a suggestion that projects that might be funded by shut-down savings could be listed for the board such as, step down units, physiotherapy improvements and pharmacy improvements. Alternately, as pharmacy layoffs were sensitive, they might be dealt with under a budget line for "board contingency" (Notes, March 13). The Nursing Director and VP Professional Services said that it did not make sense to establish step down units when they only ran the ICU at 85% occupancy.
At the next meeting, one slide was reviewed that listed potential spending areas, such as physiotherapy, pharmacy and ambulatory care, should there be a summer slowdown (Notes, March 16). There was debate about whether or not this slide should be included. The VP Medical said that with a summer slowdown, there would be 400 patients that didn't get operations and that they were closing 18 to 20 beds on top of that. There was concern that a summer slowdown was not included in the budget figures and that the Chair of the Operations Committee would react to the reference to pharmacy in the list of areas to be funded. A VP said: "We were looking good up to now and now we're coming in with summer closures" (Notes, March 16).

Another item of concern was a line in the budget for "other projects". When asked what this amount was for, the VP Finance said that it was an unidentified reserve that could be used for anything. He said that it provided a "cushion" that amounted to less than one per cent of total spending. Two other VPs thought that this answer was too vague and that it would "look bad" if they could not answer what it would be used for. The VP Finance said that together with the line item for "Board Contingency," they had more than $1 million that would keep them out of trouble if the Clinical Centre did not balance their budget. In the budget book, the Clinical Centre had a line item called "reductions required to balance" for this amount (document 200). He said he anticipated that the Board would give the Clinical Centre the revenue for certain procedures, leaving the rest of the hospital to deal with
this amount. Some VPs anticipated that Board members would think they were "hiding" something in these line items (Notes, March 16).

It was agreed that the VP Finance would follow an introduction by the EVP and emphasize the $10 million "shortfall" and mention the revenue increases proposed for parking and room rate hikes (Notes, March 13). Later, he removed the item on parking from the list of initiatives as an employee representative on the Fiscal Advisory Committee had reactively negatively to increases. When asked why increases would not be implemented until the summer, he said that the President was concerned about these as it would be "taking money from staff and patients" (Notes, March 16).

In rehearsal, the VP Finance showed how revenue increases had fallen off in recent years and showed how funding over the past three years had shifted funding from non patient care areas to patient care ones. He referred to a possible "profit" at the end of the current fiscal year and mentioned that they would like to establish a "transition fund for education and severance" with any money left over. VPs advised him not to use the word profit, but to call it a "positive variance" (Notes, March 16).

All members of the Board had been invited to the Finance Committee meeting and it was expected that one of the unions planned to have representatives attend. The EVP said that the Chairman and Vice Chairman of the Board wanted the whole budget presentation, except for personnel matters, to be public although the VP Finance had originally scheduled the whole presentation to be "in-camera". There was disagreement among senior managers over
the provision of hard copies of the presentation and whether or not to provide copies of the budget book for members of the public who attended. The VP Finance said that he would not provide hard copies of his overhead slides but that copies of the budget book could be made available to hand out to those who asked for it (Notes, March 16). Some of this "secrecy" was due to fears of leaks on the detail of layoffs, as there were ten "days of grief" between the Finance Committee and Board meetings, during which there might be stories "in the press" and employee anxiety (Notes, March 13).

When the Finance Committee meeting started, the VP Finance gave an update on the current fiscal year, noting that they were "closer to balancing" and that the loan had been paid off, reducing interest costs (Notes, March 17). The EVP began his presentation of the budget by saying that it was "the most difficult budgeting process that I've experienced in 20 years" as it had been "stressful and time consuming" (Notes, March 17). He said that the staff had worked hard and that the physicians had been "proactive," and although the presentation was brief, it represented "thousands of hours of work". He began his presentation with the budget assumptions and the principles, which he said had been "reinforced at all times throughout the hospital" (Notes, March 17).

A slide entitled, "Maintenance of Service Levels through Improved Utilization" contained a list of measures taken: bed closures, increase in occupancy rate, expansion of preadmission and same day admission unit, transfer of surgery to outpatient
surgery. He pointed out that the Ministry planning framework issued recently recommended that more than 300 beds should be closed in the local area over time and reported that they were recommending 43 bed closures, as occupancy rates in the past year were lower than usual and that on average, 20 to 30 beds were not being used. He noted that they were investing in a program to assist in maintaining services by funding a same day admission unit. He acknowledged that such a change would be difficult, that waiting lists in some areas might increase, but he advised that they would monitor the situation closely.

The Chair requested comments on the realignment of services and the Nursing Director explained how beds were consolidated. She said that there would still be some discussion with physicians on the final arrangements, but that they were trying to group areas together suitably and "not everybody got what they wanted". The Chair of the Board asked about the impact of the closures on the other hospitals and if other hospitals were closing beds that affected Riverview. The EVP identified two clinical areas that might be affected by closures at other hospitals, but reported that there was a meeting planned with the other hospitals on this topic.

The VP Finance gave a presentation on shifts in funding and projected revenues for the 1992 to 1995 period. He showed how revenue streams were changing and said that they had to generate more money. He said that balancing the budget was a "key principle" and that they had taken a "very conservative approach", given the uncertain future, by balancing the budget and paying off
the debt. He noted that to balance in the next three fiscal years, they would have to find $5 million in savings in the third year to balance. He emphasized that money from "outside the system" would have to be found and mentioned under revenues, that "a few dollars for parking increase later on during the year" were included (Notes, March 17). He showed areas of increased cost and cost reductions and reviewed the shifts in allocations, showing how patient care areas had increased slightly, while administration and other areas had decreased. He summarized by saying that they had balanced the budget and had taken a number of initiatives that would need "the cooperation of everyone in this room" (Notes, March 17).

After a review of the budget, the VP Finance mentioned that there was an additional initiative of a summer slowdown being considered that was not included in the plan. The EVP explained that it was similar to the slowdown at Christmas time and said they were doing the costing and would be taking the proposal to MAC. This slowdown would occur when demand was down and people are taking vacations and it might generate about $800K in savings.

Board members asked a number of questions on the proposed budget plan. One member asked if not including equity and growth funding for next year was being "overly conservative", but the VP Finance said he didn't think so as the government said hospitals would get two per cent in the next year and they had doubts about funding beyond the base. When a Board member asked what the Clinical Centre was doing "to help find the money" listed as an
amount needed to balance, the EVP said that the Centre was "committed to finding the money" and that he was confident that they would do so. The VP Finance said that "in the event they don't," there is "provision in board contingency and other projects, which is suspiciously close to" the amount required. Several other members of the Board expressed concern about the amount to be found for the Clinical Centre, and the VP Finance explained that there might be changes in the funding arrangements, so that out-of-province patient revenue would go directly to the Centre.

Several items that had been identified by senior managers as "sensitive" ones generated questions from Board members. The Chairman of the Board said that they needed a separate recommendation for rate increases on room differential and parking and asked about the percentage increase proposed for parking. The VP Finance said that parking increases were being deferred until July, that room rates had been discussed at the last Finance meeting and that he thought that "it was within management purview" to go ahead and raise these. The Chairman of the Board disagreed, saying that traditionally, these items went to the Board and that the background research and comparisons with other hospitals should be presented.

One board member asked if they "ever come with any other options than bed closures," noting that the Executive Director of the District Health Council said that it was "the easy way out". The EVP replied that they didn't start out looking at closing beds,
but addressed it in the context of utilization, investing in same
day admissions and traditional occupancy rates of 91%. The board
member wanted to know when a summer slowdown would be proposed and
said that it was "referred to by the public as closing the hospital
down". He wanted to know "how much is voluntary and how much
required" for staff to take vacations at that time. He was told
that it was discussed with the unions, who thought that a voluntary
approach worked better and that further work was needed to explore
the consequences before bringing it to a Board meeting.

Although the VP Finance had hinted earlier in the meeting that
board contingency and other projects items might be used to cover
the amount required to balance the Clinical Centre budget, several
Board members seemed to have missed this comment. One Board member
later asked what "other projects" was for and the VP Finance said
that it was a "balancing figure" as they had to balance in a "tight
plan" (Notes, March 17). Another board member asked about the
"board contingency" item and wanted to know what it was for. He
was told that it was for anything that came up and that it was less
than one quarter of 1% of the budget. He asked again what it was
for and several people, including Board members, explained that
there were no other funds, if "a roof caved in", etc. (Notes, March
17). Board members subsequently discussed employee layoffs during
an in-camera session and gave "approval in principle" for the 1992-
93 budget.

At a subsequent meeting of senior administrators a decision
was taken not to proceed with the summer slowdown and by the time
of the Board Meeting, anticipated motions from a Board member regarding Executive salaries and "perks" took the spotlight (document 241; Notes, April 2). At the Board meeting, although there were questions following the budget presentation about bed closures and the impact of these on services and other area hospitals, the EVP explained the shift to outpatients, measures to reduce length of stay and communications with other hospitals. Motions to approve the budget, increase semi-private and private room rates, and to establish a transition fund out of 1991-92 surpluses were carried (document 241; Notes, April 2).

5.4 Operating Budget Outcomes

The original budget for 1990-91 carried a $3.8 million deficit. When it was revised in the Fall, a $3.3 million deficit was projected. At year-end however, the actual deficit was $637K (document 241). The year-end figure however, incorporated "adjustments" and "write-offs" of more than $4 million for such items as a transition fund, a Clinical Centre "restatement" of clinical procedures, capital planning costs and bad debts (Notes, April 21). In addition, more than $7.7 million in loans had been repaid. The relatively small deficit and the write-offs and adjustments were possible because of two factors that contributed substantially to the "bottom line": more than $4 million than expected in non-MOH sources of revenue had been received, offsetting the approximately $2.5 million less than expected amount received from the MOH, and expenditures turned out to be $2.5 million less than originally projected.
Expenditures in nursing were less than originally projected ($2.8 million), as were pay equity ($1.1 million) and depreciation costs ($887K). These reductions were somewhat offset by increases in such areas as minor renovations and equipment ($1.3 million), research ($800K) and other categories. The lower expenditures in nursing were due in large part to an over-estimate of nursing rates of pay when the budget was planned ($2.5 million), and the remainder was likely due to bed closures (documents 57, 79 & 200). The loss of the 40 positions affected all divisions, but as the effect was spread across these categories and only took place in the last half of the year, there did not seem to be major shifts in allocations to the various divisions from the previous year in the final statements (document 224). The reduction of hospital beds was somewhat scattered, so that these reductions were not concentrated in any one clinical service. The one shift in allocation that did occur was an "adjustment" at the end of the year for the Clinical Centre (Notes, April 21).

In the 1992-93 operating budget, there were a few shifts in allocations among the various clinical services with the reallocation of remaining beds, but these did not appear to be major ones. The promise of a review of psychiatry and geriatrics however, may have foreshadowed changes for the future. The seven per cent increase in the salary rates for nurses in the new year and staffing for the pre-admission unit raised the nursing division budget by more than $3 million from the previous year, despite position losses with bed closures. The resulting shifts in other
budget categories were portions of one per cent and did not represent large changes in how funds were allocated, the largest perhaps from in-patient surgery to surgical day care. However, from the perspective of those in divisions, the changes were noteworthy as departments were accustomed to larger budget increases in the past. For example, although budgeted expenditures for 1992-93 increased 2.3 per cent over the current year, the 1991-92 increase over the previous year had been 7.6 per cent (document 200).

The Clinical Centre had an item of $1.4 million that was "required to balance," and as the VP Finance predicted, the Board did agree, one month after the budget was approved, to provide the Clinical Centre with revenues from out-of-province patients. Therefore, the amounts in the budget categories for Other Projects and Board Contingency were used for this purpose (Notes, April 21; document 241).

The process of budgeting underwent change in that for the first time, formal joint meetings between the Senior Medical Committee and the Senior Management Committee were held to make the last budget reductions. In response to complaints from senior physicians about their late involvement in budget planning, the EVP subsequently issued an invitation to the Chief of Medicine and the Chief of Surgery to join the weekly Senior Management Meeting, an invitation that was accepted.

The way in which the operating budget was framed also changed during the period of field work. The new budget book for the 1992-
93 fiscal year presented a total budget for Riverview, which combined revenues and expenditures from both the Clinical Centre and the hospital core, and although separate budgets were shown in subsequent sections, this roll-up was a departure from the budget presentation in previous years. This new presentation seemed consistent with the view expressed by senior physicians, administrators and board members that the Clinical Centre was a part of Riverview and that there was need for greater integration. The new budget presentation also combined revenue and expenditures into the whole that had previously been divided into "service" and "non-service" components and seemed to signify an attempt to dispel the mystique and confusion about capital funds and special funds.

In the next Chapter, themes with respect to allocation of the operating budget are discussed.
CHAPTER 6
THEMES IN ALLOCATING THE OPERATING BUDGET

In the previous Chapter, I presented a descriptive account of decision-making about the operating budget that indicated that this process was a relatively orderly one that proceeded in three phases. In this Chapter, I identify themes that emerged in the analysis of data from that overall process and discuss these with reference to the literature.

6.1 The Central Role of Senior Administrators

The roles and responsibilities of senior groups with respect to allocating the operating budget were well established at Riverview. As described earlier, senior administrators prepared proposals and consulted physicians on clinical items, senior physicians reviewed proposals and came to an agreement with senior administrators on these and the Board gave final approval. The senior administrator group was central to all phases of the process from framing the budget process to selling the final proposal to the Board of Trustees.

Senior administrators at Riverview, particularly the EVP, were in key positions with respect to resource allocation decision-making, as they were the ones with access to internal hospital information and access to the hospital network that kept them informed about Ministry intentions and policy developments. This was the only group with an up-to-date picture of the hospital's financial status and a broad, yet intimate knowledge of hospital operations. Pfeffer (1978) notes that structure not only provides
positions with formal authority and power, but also provides informal power, by placing positions centrally in an information or communications network. Senior administrators were the ones to define the budget problem, to frame the budgeting process and to set the bureaucratic machinery in motion to prepare a proposal in accordance with their guidelines. These guidelines constituted early resource allocation decisions that influenced subsequent ones.

In much of the literature, the CEO position is taken to represent senior administration (see Brooks, 1994; Lemieux-Charles & Leatt, 1992; Provan, 1991), however at Riverview, the EVP led the Senior Management Team and carried overall responsibility for internal operations, including formulation of the operating budget. Although in the absence of the EVP, the President did initiate revision of the current budget, his proposals for framing the revision process were resisted and the Senior Management Team, under the leadership of the EVP on his return from vacation, reverted to their "budget initiatives" approach and more gradual expenditure reduction. The Team's calculations, which included the effect of these initiatives, suggested that the budget problem would not be as large as that predicted by the President and they thought that larger cuts would be "disruptive" to the organization if made within a short time period. Similarly, his suggestions for additional bed closures and other cuts during the annual budgeting process were not considered feasible by senior managers. The President's role at Riverview emphasized external relations and the
future, in terms of capital projects and strategic planning; a major focus of his concern with respect to the operating budget was that there would be sufficient cash flow available to proceed on schedule with planned capital projects.

Although the President attended some of the internal senior administration and medical committee meetings and many of the Board Committee meetings, his participation was not as consistent as that of members of the Senior Management Team. The EVP, in his role as the chief of internal operations, had more sustained contact with key members of the senior medical staff and Board Committee members and placed him in the position of receiving key organizational information, a position held in other hospitals by the CEO (Provan, 1991). Therefore, the EVP took the lead in forging agreements on the operating budget with other senior personnel. Mintzberg (1989, p. 50) writes that "managers tend to be the best-informed members of their organization" and believes that this knowledge provides those who manage with the "big picture" and the ability to lead.

In the literature, many references are made to medical staff "involvement" in decision-making, but little description of how this occurs other than to indicate that medical staff "participate" and that they ought to have "input" into decisions (See Nestman, 1992; Shortt & Bukowskyj, 1994). At Riverview, formal medical staff participation in decision-making was largely confined to senior members of the medical staff, particularly the Chief of Staff, the Chiefs of the three major medical divisions and the
President of the Medical Staff. Several senior physicians held dual roles so that membership in senior groups sometimes overlapped: the Vice President Medical was a member of the Senior Management Team, the President of the Medical Staff attended weekly meetings of the Senior Management Team and along with the Vice President of the Medical Staff and the Chief of Staff, he was a member of the Board of Trustees. The Chiefs of the three major medical divisions were members of the Senior Medical Committee, the Medical Advisory Committee and the Council and two of these three Chiefs were active and vocal in hospital decision-making.

Although previously accumulated proposals from physicians, such as a long term care unit, were incorporated into the early budget building by senior administrators, senior physicians were brought into the process of decision-making towards the end of that phase. Their major contribution to the process was a decision about the number and type of hospital beds that would be eliminated, but these decisions were largely shaped by the analyses of middle managers who presented proposals based on hospital data about the current use of beds. When final budget cuts were required, the Senior Management Team invited the Chiefs of Divisions to attend a joint meeting. At the meeting, senior physicians were involved in decisions about marginal changes in expenditures for clinical services. Choices and options however, were generally ones proposed by the Senior Management Team, and late proposals for budget cuts, generated by the President and some physicians, were eliminated from consideration by the Team.
The full Board of Trustees considered an operating budget proposal at the very end of the process, although at their request, members of the Finance Committee were briefed in a very general way by senior managers during the early stage of building a proposal. For the most part, the Board shaped the operating budget in terms of the broad guidelines; senior managers knew that the Board expected that the budget would be balanced and that patient care service levels would be maintained as much as possible. Aside from these broad directions, Board members did not usually get involved in detailed discussions of how managers would meet these expectations, perhaps following the advice in a Canadian Hospital Association guide for trustees to "keep out of the kitchen" (Wilson, 1991).

Board members did not believe that they knew enough about hospital operations to actually make operating decisions and their insistence that senior managers "follow process," secure medical agreement to proposals and co-ordinate changes with other local hospitals seemed to provide them with some comfort about decisions on services. Selling budget proposals involved the members of all three senior groups, although the EVP was the key salesman. Members of the Senior Management Team helped him prepare presentations to other groups, providing him with information and backup support. Senior managers devoted considerable time and effort to selling proposals, and they did not take approval for granted. Once they had secured the agreement of senior physicians and the Finance Committee, members of these groups helped the EVP
sell proposals to their respective constituencies, the MAC and the Board of Trustees.

6.2 Evolving Relationships

As all three groups had to agree on major proposals for resource allocation at Riverview, decision-making took place within the context of established and evolving relationships between and among the three groups. While the overall pattern of roles and responsibilities was accepted by the three groups, some tension between groups was evident with regard to authority in resource allocation decision-making. Brooks (1994) describes ambiguity in the roles of the Board and CEO and the line between policy development and administration as a common source of conflict between the Board and administration. She notes that expectations change as board members change, but it seems likely that changes in senior management also have an effect. There were indications at Riverview that expectations and relationships were evolving and that these influenced resource allocation decision-making.

An element of distrust between the Board and senior administration, that was historical in nature, was evident at the beginning of field work. Board members thought that in the past, senior administrators had not kept them fully informed about finances, had made decisions without consulting physicians and others and that they sometimes made and implemented decisions prior to Board approval. This distrust made them ask if everyone had "bought into" decisions about the operating budget and question most closely those proposals apt to generate public controversy,
such as layoffs, bed closures and changes to fees charged to the public. Senior administrators sometimes expressed the view that the Board was too involved in management decisions and wanted too much detailed information, such as information on specific positions that were being eliminated. Although Board members were making efforts to focus more on policy matters rather than management issues, they did insist on their traditional practice of approving changes in fee rates that would affect the public, such as parking and room rates, even if senior managers considered those to be management decisions. During the period of field work, trust in the Senior Management Team did seem to increase and members of the Finance Committee began to comment favourably on financial management and improvements in Riverview's financial status. Although board members questioned specific decisions, they did not change the proposals in the operating budget.

Senior physicians thought that senior administrators had too much authority with respect to clinical services and they thought that they should have greater decision-making authority for management of clinical services and the associated resource allocation decisions. As their areas of interest related most to existing allocations for nursing services, conflict between senior physicians and senior managers, particularly the Vice President of Nursing, heightened during the period of final budget cuts. Senior physicians wanted changes in the organizational structure that would position them in line management roles, with greater formal authority for clinical program budgets. Members of the Senior
Management Team discussed among themselves how Riverview might change to a program management structure. They believed that cost control depended on greater physician involvement in management, but they were reluctant to make large changes in organizational structure without considering which decisions should be corporate and centralized, which decisions would be taken at the program level, and how structural changes should be designed. Senior physicians thought that senior administrators were slow to implement any change and that they were reluctant to do so. As a compromise or interim measure, the EVP held joint meetings of senior management and senior physicians during the final phase of building a budget proposal. Later, the EVP invited the Division Chiefs to join weekly Senior Management Meetings, as most members of the Senior Management Team believed that greater physician involvement in decision-making was required.

The move towards greater physician involvement in management is one advocated by Shortt and Bukowskyj (1994) who describe the traditional relationship of physicians and managers in Ontario's hospitals as "two solitudes," fostered by the traditional dual structure in hospitals, as well as differences in the physician and management cultures. In a study of hospital-physician integration in eight Canadian community hospitals, Lemieux-Charles and Leatt (1992) found that in hospitals with higher levels of integration, Board and CEO support for integration was evident. Similarly, Brooks (1994) believes that CEOs now expect physicians to get involved in decision-making and support tough decisions that
control costs. She notes that physicians prefer freedom and time to practice medicine, with minimal involvement in paperwork. At Riverview however, the views of groups were different; senior physicians pressed senior administrators for greater involvement and senior administrators seemed somewhat hesitant to embark on structural changes. Despite tensions, senior physicians respected the existing authority of administrators, although they insisted on exercising their traditional authority to propose changes in bed allocations. Senior physicians made sure that the Chief of Staff chaired the group that refined and finalized proposals, although the initial proposal was shaped by middle management. The EVP set limits on the number of beds to be closed, but despite worries about the mix and location of remaining beds, the Senior Management Team left these decisions to senior physicians.

There was less interaction between Board members and senior physicians with regard to resource allocation decision-making than between any other two groups. Board members expected senior management to secure physician approval before bringing proposals to the Board, so the need for direct Board-physician interaction was limited. Most interaction between these two groups occurred during strategic planning, a process that highlighted some conflicting views between Board members and senior physicians. Some board members thought that physicians considered their own personal and professional interests before that of the community and of Riverview, particularly with respect to their recommendations for medical appointments and strategic directions.
The structure set up for strategic planning at Riverview ensured that a Board Committee made recommendations to the Board, although a Steering Committee, dominated by physicians, was to provide the Board Committee with input. The Board Committee members pressed for information on the numbers and types of physicians at Riverview, as they believed that they were poorly informed on medical manpower and wanted to stop "rubber-stamping" medical appointments and steer such appointments in a way that would be consistent with strategic directions. As decision-making about strategic directions was protracted however, strategic planning had a limited effect on resource allocation decisions during the period of field work.

Despite tensions and conflicts, senior groups were able to agree on the operating budget, largely due to the co-ordinating role of the Senior Management Team. The Team worked closely with the members of Board committees and with the Senior Medical Committee, working relationships that enabled them to be attuned to the preferences, concerns and perspectives of both groups. This knowledge was essential in preparing resource allocation proposals that would secure the agreement of physicians and the approval of Board members; at minimum, such working relationships taught them how to sell a proposal to each group.

There are few in-depth studies of hospital budgeting that provide cases for comparison. Bradshaw-Camball's (1986) study of an Ontario community hospital does describe budgeting in the early 1980's when budget constraints accompanied changes in the funding
of hospitals in that province. As described in her account of events at that hospital, senior administrators actually made all of the proposals for cuts (which included temporary and permanent bed closures of specific units), secured the agreement of board members on the finance committee and with this committee, met with physicians and secured their reluctant agreement to the proposals. Young and Saltman (1985) studied resource allocation at a community hospital and a teaching hospital in the United States by interviewing administrators, physician chiefs, and medical and nursing staff. Based on the perceptions reported in those interviews, Young and Saltman conclude that physician and administrator interaction was the key one in decision-making in the community hospital, with physicians dominating that interaction. In the teaching hospital, the key interaction was between the chiefs of services and senior administrators, with physician chiefs dominating the interaction. Second-level administrators however played an important role in facilitating or delaying resource allocation. There are too few studies to assess if the difference in the findings of the study of Riverview with respect to the role and influence of groups relate to differences in methods, in time frame, in hospital type, in culture or all of these factors. However, both administrators and the board of trustees seemed to play a larger role in decision-making in the Canadian hospitals than they did in the U.S. hospitals.
6.3 Incremental Budgeting, Soft Information and Professional Judgement

The approach of assuming last year's or base budgets, plus or minus a percentage, is one Wildavsky (1968, 1984, 1986) describes as characteristic of budgeting in government agencies. Riverview's senior managers used this approach when they provided a guideline of four per cent cuts for departments, based on their estimates of "savings" that would be required to balance the budget. Wildavsky (1984) describes this kind of basic analysis as an "aid to calculation", one that simplifies budgeting in a complex organization. Rather than evaluating the efficiency and value of every service, Riverview's decision-makers assumed that most of them merited proportional changes in allocations. Although members of all three groups expressed dislike of across-the-board cuts, the incremental approach was used to allocate the major proportion of operating dollars. Such an approach is consistent with the concept of "bounded rationality" and the tendency of humans to seek satisfactory solutions rather than optimal ones (Simon, 1986). Changes therefore, occur at the margins and any intense examination of alternatives focuses on these smaller changes and adjustments.

There was much about allocating the operating budget that reflected a bureaucratic approach, particularly the incremental budget building of the middle stage. The major portion of the operating budget was developed using the traditional bureaucratic mechanisms described by Nestman (1992) and others. The preparation of proposals was characterized by a division of labour, with front
line and middle managers formulating proposals for their specific areas of responsibility, based on their expert knowledge and guidelines from senior management. Standard operating procedures were used to compile the budget at successively higher levels of the organization, and when compiled, the departmental proposals were trimmed further, under the guidance of senior managers, in order to achieve a balanced budget. Case reports and descriptions in the literature indicate that this bureaucratic process is common in hospital budgeting (Collins & Noble, 1992; Dorman, 1991; Nestman, 1992; Young & Saltman, 1985). Early suggestions to involve members of the Fiscal Advisory Committee or employees drawn from all levels of the organization in the budgeting process were rejected, as there was concern that this would be perceived as bypassing middle managers, a practice that would be inconsistent with notions of a chain of command, authority and responsibility. An Alberta hospital's use of a non-traditional approach to reducing the budget did generate discontent among department managers, who felt they had been left out of the process (Rennebohm & Lozon, 1992).

Techno-rational processes did not seem to play a large role in senior level decision-making about the operating budget, but were evident in some specific decisions. Their use depended on the availability of information about the costs and consequences of various alternatives, information that was not often available, and when it was, it was more "soft" than "hard". Langley-Laporte (1986) describes formal analysis as the "systematic study of
issues" that helps organizations make better decisions. Such analyses are conducted with varying degrees of formality, but at minimum, documents are generated on topics or issues, and these contain information that may be based on "soft" data or the use of sophisticated quantitative techniques. Formal analyses were not a major feature of discussions of the operating budget at senior meetings. Questions arose, often from the VP Finance who was fairly new to Riverview, about the financial impact of closing hospital beds, the savings that would accumulate from closing one Operating Room for a month and the income that might be generated from establishing a pre-admission assessment and testing unit, but the answers to such questions were generally vague or non-existent. The pre-admission unit was the one new program that came into line for funding and this decision seemed to be based on the judgement of senior administrators and their knowledge of other hospitals, rather than on any cost-benefit analysis. The decision on a long term care unit, which was supposed to have no impact on costs, was based on the judgement of senior physicians and senior managers with clinical backgrounds, that such a unit would improve the quality of care for patients.

A major problem in answering questions about the costs of procedures, programs, or projects was the absence of data and data systems, a situation that Board members found frustrating in strategic planning discussions. Even when asked by Board members to explain Riverview's seeming efficiency in comparison to peer groups, as recognized through equity payments, senior
administrators were unable to convincingly identify reasons for this. The best estimate of the relative costs of different clinical services was that provided by Resource Intensity Weights, but there were doubts about the accuracy of such estimates, given that they are based on "approximations" of Ontario cost data (Lave, Jacobs & Markel, 1991), not Riverview's actual costs. The RIW data were used to show Board members how costs might currently be distributed across clinical services at Riverview, but allocation decisions were made without reference to these data.

One area for which data were available and used was that of hospital bed utilization. Middle managers used these data in formulating proposals for the numbers and kinds of hospital beds that could be closed to improve hospital efficiency. Using data on peer-average length-of-stay, bed utilization of various services and some hospital "industry" knowledge about the consequences of operating with different occupancy rates, proposals were made for the reduction of hospital beds. In these situations, the analyses seemed persuasive in making decisions and although there was debate about bed closures, it did not centre on the accuracy of the numbers.

Despite the lack of hard data or economic analyses, there was an expressed desire for rationality in decision-making, that was consistent with Pfeffer's (1977) observation that rationality is socially valued and a "driving notion in much management thought" (p. 237). In the absence of formal analyses to aid decision-making, senior managers sought or established criteria that could
be used for such decisions as which departmental budgets could be further reduced or which management positions should be eliminated. These criteria constituted "rules of thumb" rather than any rigorous and sophisticated decision system and required considerable judgement on the part of the group using them. In a similar way, the "budget principles" of a balanced budget, maintenance of services and layoffs as a last resort served as broad guidelines for decision-making. Although there were indications that senior managers wanted to uphold these principles, to some extent they were used for the purposes of symbolic communication with board members and employee groups.

In the absence of data, comparisons with other hospitals pervaded the process of decision-making, suggesting that knowledge of what had been tried elsewhere and connections to the hospital network were important factors in decisions. Senior managers compared Riverview to other hospitals with respect to planning assumptions, bed closures, policies on day surgery, management increases, types and sizes of departments and a host of other items. Sometimes, these comparisons showed Riverview in a favourable light, such as when equity funding for Riverview was explained to the Finance Committee. At other times, comparisons were unfavourable, and seemed to be used to promote changes in methods or to justify the elimination of positions. Mintzberg (1994) has noted that managers use personal sources of information extensively and cites Aguilar's study in which personal sources exceeded impersonal sources in perceived importance by 70 percent.
to 29 percent (p. 261).

6.4 Power and Marginal Changes in Allocations

According to Morgan (1986), "organizational politics surrounds the process of budgeting and the control and allocation of financial resources" and that "one needs to have just enough control to pull the crucial strings that can create changes at the margin" (p. 161). Like Wildavsky (1984), he would predict that conflict and negotiation focus on new programs and marginal increases and decreases in base budgets.

As noted by many who have studied budgeting behaviour, participants in the budgeting process adopt strategies that are characteristic of the roles they occupy, such as budget spenders, budget savers, revenue maximizers and surplus protectors (Davis et al., 1966; Wildavsky, 1986, 1988; Mintzberg, 1983; Niskanen, 1971; Schick cited in Wildavsky, 1986). Such behaviour was evident at Riverview and contributed to the political aspects of building a budget proposal, a political activity known as "the budgeting game" (Mintzberg, 1983). Functional departments, which are characterized in the literature as budget spenders, asked for more than the budgeting guidelines permitted. Vice Presidents, especially those with major line responsibilities, occupied a dual, inherently conflicting, role as advocates of spending departments and members of the corporate team that acted as budget savers. The VP Finance acted as the supreme budget guardian, exhibiting behaviour that Wildavsky (1986) describes as characteristic of Ministers of Finance who must find revenue. Backed up by the EVP, the VP
Finance reinforced the bottom line and pressed for further budget cuts from divisions and departments when targeted "savings" were not achieved.

The shift from bureaucratic processes and incremental methods to negotiation and bargaining was evident at Riverview once the base was built and it was clear that estimated revenues were insufficient to meet the compiled budget expenditures. At this point, decision-making came closer to descriptions in the literature of a dual coalition model, a model that depicts conflict and negotiation between physicians and administrators (Harris, 1977; Shortt & Bukowkyj, 1994). There were attempts by some physicians to negotiate with senior management for additional resources for CT scans in exchange for their agreement to comply with a same day admission policy for elective surgery. When reductions in hospital beds were discussed, senior physicians attempted to insert or promote criteria that treated their services favourably, a strategy consistent with Pfeffer's (1977) description of one "relatively unobtrusive" way to use one's power.

Proposals were made on two occasions for the closure of hospital beds and these proposals were the most contentious ones in decision-making about the operating budget. On both occasions, data and analysis prepared by middle managers indicated that the number of beds could be reduced if the hospital operated at higher occupancy rates, reconfigured beds from services and shortened the length of stay with a same-day admission policy for elective surgery. During the first round of closures, the VP Medical
convinced other senior managers that there should be fewer closures and the Senior Team agreed to this, citing "disruption" as the reason for closing a fewer number of beds than initially proposed. During the second round, the EVP established the number of beds that would be closed based on analyses provided by middle management, but left final decisions on which beds to senior physicians, a decision process that was characterized by considerable tension and conflict within the senior physician group.

In a departure from traditional procedures, a new joint meeting of senior physicians and managers was instituted to discuss changes in clinical services as a result of budget restraint. For the first time, senior physicians were also brought into the discussion of broader management options for cuts, such as a management wage freeze. At these sessions, senior managers proposed cuts and asked for the views of physicians on the implications. Some decisions were characterized by mutual agreement, while others were contentious, especially those proposed by the nursing division regarding clinical services, an area in which physicians thought they ought to have greater authority. Following bargaining, conflict, and some compromise, senior physicians and senior managers were able to reach agreement on clinical issues. Two proposed cuts raised issues of fairness and were the only areas of ethical concern discussed openly at senior meetings. One was the decision to cap bone marrow transplants, of concern to senior physicians and senior managers with clinical
backgrounds, and the other was the decision about salary increases for middle management, a decision of greatest concern to senior managers. In both cases, the decision reached seemed to be an interim one in that there was a promise to review the decision, should circumstances change.

Political aspects of budgeting were not restricted to the negotiations between senior managers and senior physicians. The decision to allow no increase in senior administrator salaries was made by the Chair of the Board and the President. The President informed the Senior Management Team of this decision as the budget figures were being compiled from departments and during the period in which one Board member was focusing public attention on the issue of executive compensation. Selling the budget featured the political skills of the EVP and was characterized by rehearsals, role playing and practiced responses to anticipated questions. This behaviour was observed by Wildavsky (1986) in the U.S. budgetary process who described "the agency practice of holding mock hearings in which some officials are assigned the role of appropriations committee members" (p. 38). He considered this to be an indication of "how Congress makes its will felt indirectly", and at Riverview, the Board's will was considered carefully in preparing budget presentations. Bradshaw-Camball (1986) also describes such rehearsal behaviour prior to budget presentations to the Board at a community hospital in Ontario.

In Pfeffer's (1977, 1981) model of organizational resource allocation, power and politics influence decision-making, but
unobtrusive tactics are used. Control of information and secrecy as well as legitimation are important in the use of power and support can be garnered and opposition quieted through the use of political language and symbols (Pfeffer, 1981). He notes that administrators have an important role in legitimating decisions to the external environment and the internal coalition. A tendency towards secrecy was evident in all stages of the process, and part of the reason seemed to be that data had to be marshalled and proposals refined before releasing information that might generate opposition. For example, work on a proposal for bed reductions was not discussed openly until proposals were nearing completion. Secrecy was also evident in selling the budget proposal, as when controversial cuts were submerged in the budget presentation and only hints were given about the intended use of contingency funds. Symbolic language was also evident: a "budget initiative" had a positive ring to it, a "transition" period or fund suggested progress would be achieved after a temporary adjustment, and anything labelled "disruptive" was clearly to be avoided. Once senior managers secured the agreement of senior physicians on a proposal, senior physicians would then support the proposal and actually help to sell it to other physicians at MAC, even as they made symbolic protests that services to the community would be reduced. Similarly, members of the Finance Committee would help sell a proposal to the Board once they had agreed to it.

The shift of operating funds to the Clinical Centre was an indication that this subunit of Riverview had considerable power in
influencing marginal changes in resource allocations. In his meeting with the Executive Committee members, the Director had the support of the EVP, who had come to believe that the Centre contributed substantially to Riverview's receipt of equity funds, funds that provided the hospital with extra resources. Subtle and veiled threats by the Director that deeper investigation of the financial arrangements between the Centre and Riverview might be disruptive and disadvantageous to the hospital seemed to have an impact. Also, some Executive Committee members acknowledged past successes of the Centre and expressed their view of the Centre as a program of excellence, even before the strategic planning process had identified the Centre as one.

In a notable departure from the Board's "hands off" stance on specific decisions about operating allocations, additional Centre funding was approved, but not through the regular decision-making process. As a member of the Executive Committee, the Chair of the Finance Committee brought the proposal for funding to her Committee, one month after the operating budget had been approved. She told the Finance Committee that the relationship with the Centre was "delicate" and "had a history" and both she and the EVP presented the decision as a way to "integrate" the Centre more into Riverview. Despite some dissenting views, particularly from physicians, the Finance Committee recommended the proposal which was subsequently approved by the Board of Trustees with no discussion. As the decision was taken one month after the operating budget was approved, it constituted a reallocation of
funds in the annual operating budget and did not go through medical committees prior to approval. In the budget plan, senior administrators had anticipated approval and provided a cushion of contingency funds sufficient to cover the additional allocation to the Centre without putting the hospital into a deficit position. The power of the Centre seemed consistent with theories of intraorganizational power in that the Centre had the ability to bring in critical resources like equity funds, there was no easy substitute for Riverview to obtain these resources, the Centre had considerable institutional power with respect to visibility and number of patients (Hackman, 1985; Pfeffer & Leong, 1977; Pfeffer & Moore, 1980, Pfeffer, 1981).

6.5 Responding to Fiscal Stress

There were some signs of fiscal stress at Riverview at the beginning of field work as a deficit budget had been adopted and senior managers had started to institute measures to increase revenue and reduce expenditures. According to Schick (1980), fiscal stress is difficult to measure empirically but the perception of fiscal stress has more of an impact on behaviour than the reality. At Riverview, there were indications that those involved in allocating the operating budget perceived the organization as being under a degree of fiscal stress. The new VP Finance promoted this view and believed that Riverview's financial position had deteriorated over the past few years; those in senior positions anticipated that government revenues would continue to decline in the coming years.
The initial approaches to a deficit position at Riverview included increasing non-MOH revenues, efficiency measures, such as operational reviews of support departments and the closure of beds based on occupancy data, and the elimination of non direct care positions that were not considered essential. In the subsequent budget planning, these strategies were used again, with the addition of proportional cuts for all departments, cost-saving consultants and a shift to out-patient surgery. These measures were similar to initial ones used by six hospitals in the late 1970's and similar also, in that an overall review of programs was not undertaken (Murray, Jick & Bradshaw, 1984). These hospitals subsequently delayed action, went into deficit positions and lobbied the Ministry for additional funds. Bradshaw-Camball (1986) reports on a similar political response by an Ontario hospital in the mid-eighties. Riverview did not consider approaching the Ministry for additional funds. Like other Canadian hospitals in the early 1990's, senior groups did not seem to consider additional funds likely amid reports of a recession, and like these hospitals, they hired cost-cutting consultants (McDermitt, 1993), reduced the middle management ranks (Rennebohm & Lozon, 1992), made bed cuts and implemented day programs (Collins & Noble, 1992). Unlike some of these hospitals however, Riverview did not undertake a comprehensive review of programs, nor did the hospital have an established strategic plan to guide decision-making (Collins & Noble, 1992; Rennebohm & Lozon, 1992). Riverview's incremental budgeting persisted, despite fiscal stress, something noted by
Ezzamel and Bourn (1995) in their study of a UK university.

A number of reasons might account for the persistence of incremental budgeting and explain why Riverview did not undertake a comprehensive review of programs. It may be that Riverview experienced less fiscal stress than other hospitals or perceived themselves as being under less stress. According to Schick's (1980) analysis of governments, there are categories or degrees of fiscal stress, each of which invokes different budgeting and planning behaviour. In relaxed scarcity and chronic scarcity, evaluation activities have low priority because there are sufficient funds to cover the costs of continuing established programs. In Schick's view, only acute scarcity stimulates some evaluation activity, but even then, only by those wishing to face budget realities. Evaluation may be ignored when demands for more services are intense. Evaluation was not a strong emphasis in Riverview's response to fiscal stress.

A second reason that might explain why Riverview did not undertake a comprehensive assessment of programs is that senior administrators focused on finding organizational slack that would temporarily buffer Riverview in the short term. One response to economic stress in organizations, identified by Rubin (1980), is an attempt by administrators to re-establish budget flexibility through the control of slack funds, flexibility that is required in a period of retrenchment. Alexis & Wilson (1967) describe organizations as "uncertainty avoiders" that use strategies that aim at reducing uncertainties and stabilizing the environment.
Budget guardians engage in the creation of slack or the creation of surpluses, that provide a "cushion of excess resources" that can be used to address organizational problems or pursue goals (Bourgeois, 1981).

A key step in creating slack is building it into the budget proposal by overestimating expenses and underestimating revenues (Wildavsky, 1986). The extent to which over and underestimates were made during the 1992-93 budget planning could not be determined, but during mid-year revision of the budget, the VP Finance reported that those who had prepared the 1991-92 budget had overestimated nursing costs by $2.5 million. There was no indication that this "error" was intentional, but the inclusion of Ministry revenues to cover contract awards and pay equity adjustments was deliberate and contrary to what one would expect of surplus protectors. This revenue estimate by the previous VP Finance and others turned out to be optimistic, rather than conservative, but was characterized as a "funding shortfall" rather than an error. On several occasions, the new VP Finance did describe his estimates as conservative ones, and the year end statements for 1991-92 indicated that this description was accurate. During the most intense period of budget building, he and the EVP focused on the "$13 million problem," that did not take known and probable reductions into consideration, suggesting that they were acting as surplus protectors.

There was some evidence that senior administrators were able to gather up loose funds at Riverview. Two major opportunities for
the allocation of surplus funds were evident. One occurred at the end of the fiscal year when the financial outcomes of operating budget performance were known. Although the revised estimate of the deficit was more than $3 million, the EVP had hinted that they would probably be able to handle that amount although there could not be continuing deficits. At the end of the 1991-92 fiscal year, more than $4 million in allocations were made via adjustments and write-offs that included a sum for the Clinical Centre and a transition fund to deal with past and anticipated severance payments and staff retraining, something the EVP favoured. In addition, there had been millions in loan repayments, bringing the loan balance to zero, a goal consistently articulated by the VP Finance. Although loan repayments had been reported on regularly during the year and the idea of a transition fund had been mentioned a few times, none of these allocations had been "put on the table" for discussion at senior meetings and the Finance Committee approved the adjustments and transition fund, almost in passing.

The second opportunity for allocation of funds occurred at the end of the annual budgeting process when the revenues and expenditures were tallied. It was only at the end of the annual budgeting process that mention was made of allocations under "board contingency" and "other project" budget lines. The EVP had assured others that the Clinical Centre would balance its budget, but it was only at this end point that it became known to most Vice Presidents and Board members that reserve funds had been built into
the budget for that purpose. Even then, the VP Finance only hinted at the purpose of these funds when questioned by Finance Committee members and it was only after budget approval that the funds were actually reallocated to Clinical Centre.

In the literature, there is some evidence that subunit power becomes a more important factor in times of fiscal stress (Hills & Mahoney, 1978; Pfeffer & Moore, 1980). In contrast, other studies suggest that following an initial period of chaos, universalistic criteria become more important and that the basis of allocation becomes more rational as the organization develops information bases and uses these in decision-making (Rubin, 1977). At Riverview, the case of the Clinical Centre seemed to constitute an example of a powerful subunit obtaining a marginally greater share of resources by political means at a time of fiscal stress. However, only this unit of Riverview seemed to engage in such overt political means to obtain additional resources and there was no way to determine if this behaviour was a response to fiscal stress or was an event which might also have occurred during better economic times at Riverview. In most of the decision-making about the operating budget, senior managers seemed to want information and criteria that would provide a more "rational" and "objective" basis for decisions. They recognized that they did not have adequate information bases for decision-making, a situation that they thought was a common problem for hospitals and that has been reported by others in Canada (Conjoint Review Committee, 1988; Rennebohm & Lozon, 1992). In the absence of such "hard"
information, they established and used criteria for making such decisions as the elimination of positions. However, these criteria provided "rules of thumb" that did not entail rigorous application, nor was there any concrete proposal to develop information systems that would assist in decision-making.

6.6 Summary

In sum, the central themes identified in analysis of resource allocation decision-making about the operating budget were those related to who made decisions, the nature of the decision processes and organizational responses to fiscal stress. Senior administrators were the most influential group in decisions about changes in resource allocation from those of the previous year, in large part because their formal roles placed them in the position of controlling the budgeting process, making the proposals and obtaining key internal and external information. Their ability to obtain support for their proposals however, depended on their relationships with senior physicians and key board members. These relationships underwent changes as the process of budgeting unfolded, with growing confidence in the senior management team by the Board and greater input into budgeting by senior physicians.

Incremental budgeting was the core of the approach to allocating the operating budget and in a time of perceived fiscal stress, this meant across the board cuts to services and departments. The process of building the core of the budget was largely bureaucratic in nature and this was characteristic of the framing phase and most of the building phase; political processes
were more evident during the mid to final phase of building the proposal and throughout the selling phase. Techno-rational processes were considered desirable and were used for some decisions, such as bed reductions, when data were available. For the most part however, decisions were heavily influenced by professional judgement, rules of thumb and informal knowledge of the experience of other hospitals. One subunit of Riverview seemed to have considerable power in increasing its allocation through political means.

Riverview seemed to be experiencing a degree of fiscal stress and the initial response seemed to be an across the board cut, but no comprehensive review of programs. In addition, a successful attempt by senior administrators to gather up slack funds seemed to provide Riverview with the ability to prepare for anticipated reductions in the future, address the demands of the Clinical Centre and place Riverview on a firmer financial footing. However, despite a desire to make decision-making more objective and rational, no formal steps were taken to collect internal or external information that might assist in future decision-making.

Although the above analysis focuses on decision-making about the operating budget, these decisions were tied to those about the capital budget. In the next Chapter, the process of making decisions about the capital budget is described.
During the period of field work, the capital budget was discussed on numerous occasions, but the process of decision-making differed in several respects from that observed during operating budget decision-making. The President, rather than the Senior Management Team, steered proposal development and aside from the Director of Planning, middle managers and the operating core were not involved in building the major portion of this budget. Decision-making about most capital items was not tied to a specific time frame and phases, such as those described for the operating budget, were not as clearcut.

7.1 Background on the Capital Budget

7.1.1 The Five-Year Capital Plan and Strategic Planning

In June 1990, the President had submitted a "Final Report on Phase III Redevelopment" to the Board of Trustees that contained a five-year proposal for capital spending (document 19). Six "priority" items were listed as: Operating Room (OR), labour and delivery suite, Research Centre, Clinical Investigations Unit (CIU), magnetic resonance imaging (MRI) unit and a parking addition. Two other lists, one for items listed as "ongoing retrofits" and one for renewal projects with undetermined dates, were presented for a total budget of $51 million. In addition, there were numerous items listed in an appended "capital spreadsheet" such as, on-going projects, recruitment and research costs, annual capital equipment costs and minor renovations. These
other items totalled more than $73 million. An item for "computer system", identified as having zero costs, indicated that the expended costs by June 1990 of more than $2 million would be recovered starting in the subsequent fiscal year.

As mentioned earlier, revenue sources in this plan included estimated annual amounts from depreciation and other non-cash expenses, anticipated and existing capital grants and estimated amounts from bed differential revenue and fund-raising. The "bridge financing" required to carry out the plan peaked at about $19 million, although the debt load authorized by the Board was $25 million (document 19). The report noted that the Board had made a decision to cancel one previously-approved project as the provincial government had delayed policy decisions on this specialty area for several years. Therefore, it was unlikely that capital funding grants for such a project would be received and thus it was considered "no longer viable".

In February 1991, the Board of Trustees authorized the President to submit three of the capital projects to the Ministry of Health for approval with the following estimated costs:

<table>
<thead>
<tr>
<th>Project</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR Project</td>
<td>$17.4 million</td>
</tr>
<tr>
<td>Clinical Investigations Unit</td>
<td>.9</td>
</tr>
<tr>
<td>Research Centre</td>
<td>11.0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$29.3</strong></td>
</tr>
</tbody>
</table>

The Board also adopted a motion that defined the following order of priority for construction: Clinical Investigations Unit, OR Project and Research Centre (document 27). The notes to the proposal indicated that the hospital debt load would peak at $19.5
million and that the authorized debt load had been revised downwards to $20 million (document 23).

The proposal for a CIU had been approved in 1989 and it was viewed as a unit that would support clinical research through clinical trials, conduct epidemiological and evaluative studies and enable Riverview to "look at health care delivery and new technology assessment" (document 19). The intent was to renovate some shell space in an existing hospital building for the CIU unit, which would provide offices for researchers, conference areas and space for computer equipment. The OR Project, also approved in 1989, had grown in size by early 1991, raising the costs by $3.5 million. Additions to the project included new instrument and supply areas, a satellite laboratory and pharmacy and an increase in the number of operating rooms, ICU beds and pre-operative beds. The project would provide Riverview with up-to-date ORs and accommodate more sophisticated, quaternary-level surgical procedures. The third phase expansion of the Research Centre had been recommended in 1990 by the former Strategic Planning Committee and was approved by the Board in that year. The expansion would enable the Centre to proceed with its planned research programs and was seen as advantageous in "recruiting new Division and Department Chiefs" over the next years (document 19). The costs of this project had also increased by 1991, and $1 million for additional laboratories was added to the approved estimate (documents 19, 23).

When the three projects had been proposed for funding, each of them had been tied to the "four foci" developed in an initial
attempt at strategic planning. As noted earlier, senior physicians had refused to accept this original strategic plan or to recommend capital spending flowing from it. For that reason, at the time of field work, Riverview was engaged in a new strategic planning exercise. At the same time, Riverview was also participating in a university-driven strategic planning exercise that addressed rationalization of local hospital services. Although such strategic planning was underway throughout the field work, there was no direct discussion of how priority capital projects might be altered by such strategic planning efforts and planning of priority capital projects proceeded on the basis of the Board's earlier approval of these.

7.1.2 Perspectives on the Capital Plan

The President believed that in order to position the hospital for the future, "strategic planning has to be really good" and that the future would bring a smaller hospital with more specialized services (Interview 7). He expressed a sense of urgency for Riverview to identify Programs of Excellence as rationalization decisions had to be made, government resources were declining and he believed that major capital projects, such as those underway at some other hospitals, would not be seen again. In discussing capital redevelopment, he told me that they would have to be very careful to avoid a deficit in the future, that fundraising would have to bring in more and that Riverview would have to "look to our own resources" in the future. He told me that he "got badly burned" and "ran up enormous bills" in planning a previous project
that subsequently fell through when he couldn't get basic government approvals "to get it off the ground" (Interview 7).

The President told me that he wanted a medium-term business plan as otherwise "I don't know how I can do impact analysis of physician" appointments, "I don't know how I can plan for capital equipment" and "I don't know how I can do program budgeting" (Interview 7). He said that he wanted to get the VPs talking about a three-year plan:

PRESIDENT: I want a plan. A new plan. That ties in totally to resource allocation. Whether it's a strategic plan, an operating plan or a whatever, I need a corporate plan. At that level. (Interview 7)

As described earlier, in August, 1991, the President became concerned that the operating deficit might grow and that "nervous" Board members might want to cancel or postpone capital redevelopment. As the President hoped to begin breaking ground in the Fall, his direction to the Senior Management Team was to rework the budget to eliminate the deficit, consider the "optics" of having layoffs at the same time as construction and avoid criticism of the government as a $5 million capital grant for the OR Project was at stake. He told them that the first goal was to balance the budget and the second was redevelopment so "we can progress" (Notes, August 21). At a subsequent meeting of the Senior Management Team however, he revised the goals making the third one, after community services, rebuilding of the OR and continuing "our intellectual growth" via the Research Centre (document 37). He emphasized that "the hospital has to firmly be a centre of academic and research excellence" (Notes, August 26).
Members of the Senior Management Team had been less involved in the development of the capital spreadsheet, although they were involved in spending decisions from the annual capital equipment fund. This involvement was evident when I asked VPs about the capital budget and they responded by discussing the $3 million annual amount dedicated to capital equipment purchases and replacements as this was the part of the capital budget that they developed along with the annual operating budget (Interviews 1, 3 & 4). When I clarified that I was asking about the total capital spreadsheet, VPs described the "mystique" associated with capital plans. Several told me that the new VP Finance was demystifying the sources of funds and financing of the capital budget:

VP:  [The VP Finance] has come in and he's got a whole different...people have grown up in a culture of these two pots and in fact, I can remember when I first came here and people...and [one project] was growing in leaps and bounds...and we had to put the kibosh on it and every time, you know: "well there's no problem, it's capital". Well, what does that really mean? There's only one pot. If you're spending more money than we have, there's only one way of getting it and that's at the bank to loan this money to pay for it. (Interview 3)

Senior managers were concerned about Riverview's loan and borrowing money for capital redevelopment. Early in the field work period, one VP told me that they did not do what other hospitals did for capital expansion in that they borrowed from the bank and there had to be a "serious look" at whether or not they could pay the bank (Notes, August 6). At the beginning of field work, the outstanding loan balance was at $7.7 million and the VP Finance noted on several occasions that he planned to pay off this loan with funds received for equity and growth funding (Notes, September
Although the Chairman of the Board of Trustees and several of the Board members had changed since the capital plan and capital projects were approved, there was considerable continuity of board membership. The former Chairman continued as Past Chairman on the Board and Board Committee chairmen were drawn from those who already had some Board and Board Committee experience. Under the past Chairman's leadership, the Board had established the OR project as the key priority and according to one Vice-President, it had done so because surgeons had used "scare tactics" about the OR being "unsafe" (Notes, November 25).

The Finance Committee reviewed proposals on capital projects from the President and proposals on capital equipment from the Senior Management Team prior to Board meetings. Board members seemed somewhat cautious about proposals, especially with regard to large capital projects, and they were somewhat uneasy about their role in decision-making and the degree to which they should exercise control:

BOARD: ...You know [the President] was forever announcing the completion of a building project. We finally had to say, "Well stop, you can't hire any more shovels until it's been approved." Then he'd stop. But maybe that wasn't the sensible decision either. I mean we should be looking at them individually. (Interview 7)

BOARD: Well we have a finance meeting next week and that's one of the things we're going to be looking at and I think we need to do a revisiting of our capital expansion program. Not that the Board wants to hold the hospital back. You see, we have at Riverview a builder President. Which is admirable, uh, he is a go-getter, he is a builder and I guess the Board has to--you have to be careful that you don't stifle somebody like that or do his thinking for him. ....A controlling--that's a bad one--a community voice that can temper uh, temper
the desires of a builder President, that can bring a community perspective to the desires to be first in research and leading the country and all the rest of it. (Interview 9)

The physicians involved in discussions of capital budget items were Division Chiefs, particularly those on the Senior Medical Committee, as well as those in the positions of Chief of Staff, President of the Medical Staff and, representing the Director of the Research Centre in his absence, the Assistant Director. Although some senior physicians expressed no strong opinions with regard to the priorities for the capital budget, the Chief of Surgery was very involved in the detailed planning of the OR project and advocated for its importance. The Chief of Medicine, who was an active researcher, was strongly supportive of the CIU and the Research Centre, as was the Assistant Director of the Research Centre. One senior physician emphasized the link between strategic planning and capital expenditure:

PHYSICIAN: And if this institution is serious about changing its role and function, then as far as I'm concerned what we're talking about is the influx, at least in [my Department], of investigators who can at the same time teach, and who can at the same time deliver the best quality patient care. So I'm very wedded to the Research Centre. Because I think that's the thing that's really going to change the way this place runs. (Interview 13)

On the whole, the senior physicians supported each other with respect to planned capital projects that forwarded the goals of their respective Divisions. However, they wanted projects to reflect directions established in a strategic plan that had the approval of the medical staff at Riverview before agreeing to major capital spending. One senior physician told me that at an early strategic planning retreat, the "real agenda" that came out on the
table after initial discussions was the President's wish to allocate funds to capital projects and physicians resisted this approach (Interview 13).

7.2 Capital Allocation Decisions

Although decisions about capital items did not seem to take place within a prescribed time frame, decision-making about the annual capital equipment fund was an exception. Several requests for capital equipment or renovations emerged from the operating core and required decisions, while others were forwarded by the President for approval as progress on projects proceeded. However, key decisions were eventually made on the overall "capital plan" as major projects increased in costs and there were growing doubts about Riverview's ability to finance major projects. Although various versions of a capital plan were presented at senior meetings, it was not until the last months of the study period that a comprehensive plan was presented to senior groups for decision-making.

7.2.1 Capital Equipment and Renovations

As part of preparation of the 1992-93 annual operating budget, a call for requests for new or replacement equipment was issued in early Fall. The Capital Equipment Committee members reviewed submissions, requested presentations from departments on some items, set priorities based on established criteria and recommended items, up to the limit allotted, to the MAC and then the Finance Committee (document 116). The VP Professional Services, who chaired the committee, reported that requests in excess of $7
million had been received and that there were many requests for computers and computer-related equipment (Notes, November 18).

A designated fund for minor renovations was also advocated when senior managers reviewed a list of minor renovation requests submitted to the Planning Department. From a list of items totalling $2.7 million, the VPs selected priorities from each of their Divisions and allocated the $145K in funds that were available (document 127; Notes, November 25). The VP Finance noted that they could deal with these many requests by using the cash flow and suggested that perhaps the major capital projects should be delayed so that they could take care of all the minor renovations. Of particular concern were several renovation projects for the Emergency Department that totalled more than $400K. The EVP said that they would have to deal with these requests separately, as there had been a media story about the department and during the "trial" accreditation of the department, a number of concerns had been identified by staff (Notes, November 25).

In January, equipment recommendations for the next fiscal year were presented to the Senior Management Committee. The VP Professional Services reported that a portion had been set aside for computers and she presented a list of recommended equipment that varied widely in the amount of funding required (document 152). Two items for more than $500K each, one of them a digital dictating system, had not been included and the VP Professional Services said that these large requests created problems as there
was nothing in between the capital equipment budget and the capital redevelopment budget (document 152). It was agreed that the Capital Equipment Committee would be reconvened to discuss the digital dictation system, as the President of the Medical Staff thought that at least the radiology portion was needed immediately.

A revised list was presented to the Senior Medical Committee and participants seemed satisfied with the proposal, which included the dictation equipment (document 148; Notes, January 15). It was noted that the process had improved in the last few years. At one time, requests amounted to more than $18 million and some believed that the commitment to having a capital equipment fund explained the declining requests. The Committee planned to ask departments for a three-year capital equipment plan so that more long-range planning could be done (Notes, January 15).

The capital equipment proposal was approved by both the MAC and the Finance Committee with few questions (Notes, January 20 & 21; document 176). When one Board member commented that there was an item missing, the President explained that he was referring to a lithotripter and that it would be included in "some other budget" he dealt with, probably for 1992-93. He explained that he was seeking MOH approval for a lithotripter and that it was a resubmission of an earlier proposal, but this time in conjunction with another hospital. He reported that he had included the item in his three-year business plan that was due out shortly. When the Chair asked if there were funds for it, the Board member who had asked about it said that there was a $300K fund for it and that the
machine could be leased. The Chair of the committee expressed concern that there was nothing set aside for contingencies in case something broke down, but the VP Finance said that capital equipment purchases totalled $3 million out of a possible $15 million in available cash flow, so that funding could be provided for emergencies.

In early March, the Executive Committee met with the Director of the Clinical Centre who was following up on an request he had made in an earlier letter that the Centre receive additional funds. He requested all of the revenue from semi-private and private bed differentials from Centre beds, instead of the 36% the Centre currently received, as well as depreciation expenses as the Centre's budget included depreciation, but they did not benefit from Riverview's capital equipment fund (Notes, March 11). He said that Riverview benefitted from the Centre's activities in that their work contributed to the equity and growth funding that was received, but he acknowledged that there had been some talk about doing a detailed breakdown of overhead expenses that Riverview carried on behalf of the Centre. Although he was willing to engage in such "number-crunching," he advised that it would be "disruptive" and "nonproductive" to start "haggling".

A Board member asked what was done historically with differential revenue, so the EVP explained that two thirds had gone to operating budgets and one third had been reserved for capital projects. The President said that they had tried to preserve that fund as they had no other source of money for capital. Some
concern was expressed that these funds would now be "eroded" and used for operating costs in the Clinical Centre, but the EVP noted that it was "an issue of fairness". Several Board members said that they did not support "number-crunching" and agreed with the Director that it would "divide" the hospital. When the Chair of the Finance Committee said that giving all the differential to the Centre would be a decision for one year, another Board member disagreed, saying it would probably be required in subsequent years (Notes, March 11).

There was some indication that the Board would meet the Director's request if the Centre was identified as a Program of Excellence (POE) for Riverview. One Board member said that from his perspective, the Centre was a POE, although another noted that the strategic plan would be coming later. The Board Chairman said that in "some sense it was already decided" that the Centre was a POE, although there would probably be a second one as well (Notes, March 11). There seemed to be general agreement to "avoid separation and dissention" and that a "fair and equitable arrangement" should be worked out.

When the Finance Committee discussed a recommendation that the Clinical Centre be allocated $500K annually for capital equipment, rather than making an adjustment on bed differential income, there was considerable debate as well as resentment from some physicians who questioned what Riverview would do when the Centre came "begging again" (Notes, April 21). The EVP presented the proposal as an attempt to "integrate" this part of the hospital more fully
into Riverview, but some Board members expressed concern about having to "scale back" some other capital projects. Several others were reluctant to approve the amount in the absence of a strategic or capital plan (Notes, April 21). When asked where the money came from, the answer was "from capital". They returned to this item later in the agenda and approved the recommendation, but did not present it at the April meeting of the Board as they wanted to wait for an overall capital plan (document 241).

In addition to planned capital equipment purchases, some consideration had to be given to unanticipated requests that arose during the fiscal year. One such request was brought directly to the Finance Committee by two senior managers who presented a proposal to replace two Computerized Axial Tomography (CT) scanners. They explained that one of the current scanners was old and would soon require replacement and the other, although relatively new, was not working well. The VPs recommended that two new scanners be leased and they provided the Finance Committee with nine pages of documentation that outlined the financial aspects, the benefits, a decision analysis matrix and the stages of review carried out during the past four months (document 90). A team of five physicians and other technical and financial specialists had visited other hospitals and vendor factories as part of a 15 step-process leading to the recommendation to lease two machines from one company. The projected operating costs were similar to that for the current scans, although capital funding of $300K for mechanical modifications would be required. The VP Finance said
that the proposal made "economic sense" and that there was a wish to have it approved that day as the value of one machine being traded in might drop in value by $300K when the new generation machines were unveiled at the radiological society meeting next month (Notes, October 15). They noted that because of the unreliability of the current CT scanners, the waiting list was at 10 weeks.

Board members said that they found the documentation and presentation difficult to follow and that they were unclear as to whether the figures presented included depreciation. The President said that he had been preoccupied with another issue recently and so he was not up to date on the proposal. He asked if getting two machines was a "patient care advance" and asked if they should not instead be getting an MRI. He cast doubt on the proposal by asking again, "Are we advancing patient care?" and "Are two deluxe machines needed?" When the VP Finance repeated that the deadline for arranging the deal was that day, the President said, "Nonsense". A Board member asked the President how long it took to get Ministry approval for an MRI. He replied that it would have to be "worked through the system", but that he "wasn't worried". He then asked if anyone had checked into the volume of MRIs required at some community hospitals and as no one had looked at this, he suggested that it should be done.

One Board member expressed frustration about being presented with this proposal with the expectation, "Now sign off boys and girls" (Notes, October 15). He said that he did not like having an
imposed time frame and that if the Finance Committee was to be a
decision body, it couldn't operate in this way. In defense of the
proposal, the Chief of Staff said that the Senior Medical Committee
had approved it and the VP Medical said that CT technology was now
becoming more routine. A physician member of the Board concurred
that it was no longer a "frill or fancy".

A motion to authorize the two leases was put forward, but did
not have seconder as the President was concerned that if the motion
was approved as worded, they would lose bargaining power with the
company for a deal that included MRI technology. He wanted more
time to discuss the possibility of a package with the company
before a decision was made and so a second motion was put forward,
but was lost when there was no seconder. Following much
discussion, it was agreed that "the President and his staff" should
explore negotiation further with the company with regard to
inclusion of an MRI in the package with the two scanners. It was
agreed that they should not take this item directly to the Board
meeting the next week as the Board would "come to it cold".

The Senior Management Team held a "debriefing session" on the
meeting later in the day and reviewed the problems that they had
encountered in gaining approval. They realized that they should
have mentioned problems with the existing scans earlier and not
surprised Board members with the request. One cautioned that they
should "remember the history" and that they could not suddenly
present an item for approval. They did think however, that the
scans would had been approved if the MRI issue had not been raised
by the President. They also considered how data should be presented to the Board members and that patient care information should be presented "hand in hand" with the dollar information (Notes, October 15).

At a follow-up meeting the next week, the CT scanner proposal to lease two machines was considered and approved (Notes, October 22). The proposal was accompanied by eleven pages of back-up material, but this time the financial summary was replaced with an overall summary that included a patient care rationale at the beginning. A comparison of purchase and lease from two companies, in terms of discounted cash flow and costs, was provided (document 98). The VP Finance reported that the company was not prepared to link CTs to MRI equipment and estimated the potential cost of an MRI when capital expenditure, site preparations and operating costs were considered. A Board member, who was not present at the previous week's meeting and who was a businessman, said that he had gone over the figures with his accountant and they both thought that it was a good deal. The President did not participate in the discussion, except to mention at the end of the meeting that he should talk to the MOH about approval of MRI equipment (Notes, October 22). Later, a VP told me that they had "worked the phones" prior to the meeting to ensure that Board members would accept the proposal.

When the proposal was presented to the subsequent Board meeting, the Chair of the Finance Committee noted that there was a 10-week waiting list for scans. One Board member asked: "Is this
what the medical people want to do?". Two physicians reported that the Senior Medical Committee had supported the proposal and one physician also said that the new technology provided more space so that patient waiting areas could be improved. The Chairman of the Board said that in talking to Board members about the CT scans, a concern was expressed that the item came forward quickly and they needed to address how to resolve this. He said the Board should have heard of it a while ago and the issue related to the future, to planning and to budgeting. He emphasized that, on major items, the Board should be warned and not suddenly presented with a proposal. However, the Board did approve the funds required to install the new scanners (Notes, October 24). When the Senior Management Team later prepared a presentation for a new gamma camera head request, they warned Finance Committee Board members one month beforehand and applied some their earlier experience in successfully gaining approval (Notes, December 17).

Several months later, the Chief of Radiological Sciences reported that they were looking at options for imaging services as the turn around time for services at another hospital with an MRI unit was too long and the equipment at that hospital was aging. One option being explored was that of purchase and the Chief noted that the President had told him to "find a hook" that could be used with the Ministry, such as research or the provision of services to other hospitals. One of the concerns was that several of the radiologists with training in imaging were losing their skills; another concern was that access to services was difficult. The
Senior Medical Committee agreed that a multidisciplinary committee should be set up to investigate the issue further (Notes, January 22).

7.2.2 Stalled Decision-Making

The original capital spreadsheet had contained numerous projects, three of which had been identified as priorities—the CIU, the OR project and the Research Centre. The President consistently expressed a desire to proceed with priority projects, but he encountered numerous delays and resistance to his attempts to get these projects underway. For a period of six months, decision-making on major capital projects seemed to be stalled. Some of the reasons for the delay were external and some were internal, but all involved interaction and conflict among the three senior groups.

The initial threat to proceeding with priority projects occurred when the current year's operating budget had to be reduced to prevent a growing deficit that alarmed the Board about embarking on capital spending. In addition, costs of the OR project had escalated by another $7.2 million above the amount last approved by the Board. At that time, the President tried to "reassure" members of the Board's Executive Committee that Riverview could cope with a current year deficit, proceed with the capital projects and stay within the previously-established borrowing authority of $20 million:

President: We won't do capital spending of $19 million because the OR won't start until late November, the Research Centre won't start, hopefully till late November, so we're going to spend much, much less because
of the approvals from the government on our capital works next year--therefore, we should be able to absorb $3.2 million deficit this year--begin some of the capital spending this year--not as much as we expected, but getting into the ground, not go over our debt limit that the trustees have approved of $20 million and then [the EVP] will have balanced the budget starting April of next year, which will enable all those projects to keep moving. (Notes, September 6).

As described earlier, Executive Board members expressed concern about the tradeoffs in favour of capital projects and expressed doubts about the wisdom of borrowing. The Chair of the Finance Committee reported alarm about the OR project:

Finance Chair: I can tell you that the last Finance Committee meeting uh, there was considerable discussion of the capital program. I don't think [President], that you will find any argument from anybody re the necessity for a OR suite. There is no argument. The only argument left in my mind, is how big, how fancy. That's all. Do we need 14 or do we need 10 operating rooms? Do we need Cadillacs, do we need Ford Tempos? (Notes, September 6)

The President agreed with the concern about the growth of the project and he said that a retreat had been organized with the OR planning group to address those issues. The President later convinced the OR planning group to reduce the cost of the project back down to an amount that ensured the borrowing limit was not exceeded. In doing so however, the VP Finance was asked to "find" more than $1 million elsewhere for step-down units and other items that would no longer be considered part of the project (Notes, September 9).

Finance Committee members continued to worry about Riverview's financial stability and the ability to do projects, so in October they agreed to establish policies for financial governance during the coming year (Notes, October 15). The President was aware of
Board concerns about financial stability and told me that the Board had given him the following order of priorities: fiscal viability, quality of care, community service and lastly, redevelopment (Interview 7). He also told me that he had just received a report on the problems of a debt-ridden hospital in the province which he considered to be "totally incomprehensible from the way I operate". Board members were also aware of this report and made references to it during meetings, one Board member asking, "Where was the Board?" (Notes, November 19). They questioned the ability of Riverview to "move an ambitious program" on the capital side and told senior managers that the constraints on operating budgets also applied to capital budgets.

Other issues arose during the Fall and early Winter that threatened to delay decision-making on capital projects. One of these was a decision by the City's Planning Committee to change the regulations on Floor Space Index (FSI) and parking standards. As FSI regulations relate to the relationship of building square footage and land square footage and as parking had been an ongoing problem for Riverview, the President was concerned that changes would affect approvals of the capital projects. He asked for a meeting of the Executive Committee to obtain their advice and it was agreed that the hospital should take a low key approach initially, but have their legal firm object to the changes in a brief to the City's Planning Committee (Notes, September 17). The President informed middle managers that Riverview would fight these "limits to growth," that he was worried about the OR and the
Research Centre projects and that they might have to wait until Spring to start construction. He also told them that the budget for redevelopment was separate from that of operations (Notes, September 27).

The President attended the end of a Senior Management meeting in early October to report that they were unsuccessful at the City Planning Committee meeting with regard to parking standards and FSI. He gave them a proposed Board motion that would be discussed at a special Board meeting and indicated that there might be a fight to get the City to change the proposed regulations (Notes, October 7). At the Special Board Meeting, trustees discussed a motion that opposed the Planning Committee proposals and gave the Chairman the authority to implement "a strategy which would express our opposition" (document 84). Three members of Riverview's neighbourhood community association attended the meeting and one of them spoke, saying that parking had been an issue for 20 years. He said that the hospital did not always work with the community and that in the past, the hospital had been secretive about their plans for expansion.

Two municipal politicians, who were also Board members, opposed the motion, but it was adopted. A motion was put forward by one of the politicians directing Riverview to write to the City to request funding to build more parking and this motion was also adopted. The politicians, who were in the midst of an election campaign, asked about the "strategy" referred to in the first motion and if the hospital would get the press involved (Notes,
October 9). The hospital subsequently organized a campaign that generated calls to City Hall and petitions signed by employees and patients that argued against regulations affecting parking at the hospital site. The President thought that this strategy was working when he received a call from the politicians asking for a meeting (Notes, October 10). He reported that they wanted to defer the Planning Committee motion and do a zoning study, so in the view of the President, this was a success due to the "power of public opinion" (Notes, October 15).

In November, the President brought forward the issue of a heliport for Riverview. He had been working on an agreement to lease land because some time earlier, the MOH had encouraged heliport development to reduce the costs of maintaining road ambulance crews. The President sought the advice of "senior people" at a meeting of the Strategic Planning Steering Committee on a lease agreement that he had been negotiating. The costs of building the heliport were $300K, but the provincial government would now not provide money as the fund for this purpose had been exhausted. The Chief of Surgery said that he would support going ahead with it as the decision not to build it would determine rationalization of acute care. In his view, by not building it, it would "swing acute care away from the hospital". A Board member who was present said that the Board would want to know what priorities were going to be changed because of this outlay. He said that he did not completely agree with the Chief of Surgery's argument because a decision to do it would also pre-determine
rationalization. He wanted to know what impact doing the heliport would have on other priorities and if the landlord would require Riverview to return the land to its original state, if a decision was made to end the agreement after five years. The Chief of Surgery said that he had no idea of the numbers of flights that would occur, but if the service was available, there would probably be an increase in its use over time. The President said that based on the discussion, he had the impression that most people supported going ahead with the agreement (Notes, November 20).

At a subsequent meeting of the Executive Committee of the Board, the President reported on the proposed contract to lease land for the heliport for $30K per year and said that he would like to sign the document by the end of the year. The Board members asked that he bring a history of the project to the Board meeting at the end of the month. Pre-circulated documents for the November Board meeting under the Executive Committee report included a memorandum from the President, a history of the heliport project and preliminary cost estimates. In his memorandum, the President had written that "this program fits with one of our strategic foci," citing two foci from the abandoned strategic plan (document 132). The item was not discussed at the Board meeting however, as the Chairman said that it would be going to the Finance Committee next (Notes, November 28). The President told the Senior Management Committee later that he was "being hammered" by the Board on a number of issues and that with regard to Board operations, it was important that they "follow process". He said
that there should be no last-minute items and that nothing should go to the Board unless it had been through a Board committee, citing the incident of the heliport and how he had to "pull it back and send it through Finance" (Notes, December 2).

The Finance Committee considered the proposal for the heliport at their next meeting. The rationale presented in the new documentation cited a service objective: "to provide improved access for critically ill and injured patients to tertiary care service". There was no reference to a specific strategic focus or POE, but a second objective given was: "to prepare for the future rationalization and regionalization of specialty services" (document 142). Flights were estimated to be approximately one per day during the year and the net capital costs were estimated. Board members asked questions about start-up and maintenance costs, technical aspects of operation, what other hospitals had heliports and how these had been financed. One Board member was angry that the Ministry wanted heliports as they saved money, but was unwilling to "pick up the bill". Despite this objection, most Board members were supportive of the project as "this sort of thing is quite consistent with the direction," Riverview would "gain a bit of competitive advantage over the other institution" and such a decision would "work to our advantage" (Notes, December 17; document 153).

Discussions about the heliport project illustrated the link that most senior decision-makers made between strategic planning and capital project expenditures. However, capital expenditure and
rationalization questions were raised before hospital strategic planning decisions were finalized, causing conflict between the President and the senior physicians, who viewed the President as circumventing the strategic planning process at Riverview. On three occasions, the President and senior physicians engaged in open argument about the process and sequence of decision-making.

In the Fall, the Steering Committee was just beginning to identify the criteria for "Programs of Excellence" (POEs) that would be favoured in future resource allocation decisions (Notes, October 23). The President, along with other teaching hospital CEOs, was a member of the university's Rationalization Committee. That committee was proceeding with a "straw dog" document on how services might be redesigned for the region through shifting of services among existing hospitals. He told the Steering Committee that they would have to do a "rough cut" of POEs and report back to the University by the end of November, so in his view, criteria had to be ready for a retreat meeting. A Division Chief, who was also very involved in the university process, did not agree that decisions were needed by that date. He objected to mixing rationalization decisions with those of POE selection saying: "we are trying to do two things at once--how to deal with the financial crunch by chopping and programs of excellence". The President seemed frustrated and said that another hospital had made choices and it "was simple for them--they just used a common sense approach, took a list of services and identified two" (Notes, October 23).
The planning consultant referred to the experience with the four foci and said that his impression was that people felt that someone had taken it and "cooked it up on a weekend". He emphasized the need for wide discussion to avoid that perception as reallocation of monies would be involved. There was some heated discussion on the process of arriving at identification of the programs of excellence. The President repeatedly said that a list was needed by the end of November and asked: "How are you going to help me achieve this?" Two physicians argued that decisions were not needed by that date and it could not be accomplished by then if all of the medical staff was to be involved.

A Board member said that one problem he saw was that "in no way is this [POE selection] market driven" and that it "must reflect a requirement in the market place". He said that they had some data from the earlier stage of the strategic planning process but a Division Chief argued that these data were only local and that "we will be responsible for part of the province" and that those data "were not at hand". In the consultant's view, the choice involved "competitive strategy" and he asked: "what is the likelihood that this will become a centre that will attract money, people, etc.?", given the strengths at other provincial locations. The participants continued to discuss process, without resolution. As another meeting was scheduled, the President ended the meeting and said that they would have to meet and work out a schedule to ensure that he had the decisions by the end of the month. When he left, a Division Chief said: "we are being stampeded once again by
the President" (Notes, October 23).

At the suggestion of a senior manager in December, the Board Committee agreed that a preliminary list of potential POEs should be developed so that these could be "protected" during the rationalization process (document 149). A letter was prepared for all medical and administrative department heads and physician chiefs inviting them to comment on the proposed definition of and criteria for POEs. They were also asked to identify existing programs that "most nearly qualify" as such programs (Notes, January 15). As meetings of the Steering Committee had not been called for several months by the President, the strategic planning seemed to be proceeding via decisions of the Board Committee. Therefore, the Division Chief who was also key in the university planning process, asked to attend all future meetings of the Board Committee and that Committee agreed in January to invite him (document 163).

The President's concern about speeding decision-making stemmed in part from the pressure exerted by the Board Chairman and other Board members to "follow process", balance the budget and sort out the capital projects, keeping in mind the priority of the OR project (Notes, December 2 & 9). In part however, the President was receiving growing internal pressure to delay the capital projects. The senior managers had already identified the need for funds for management information systems, capital equipment and renovations (Notes, November 25). In addition, an Emergency Department report to the Board's Operations Committee had given
impetus to the need to find renovation money for that part of Riverview. With the President, senior managers had also identified a list of "outstanding" capital issues that had to be included in a revised capital plan requested by the Finance Committee (Notes, December 7 & 9).

In early January, the EVP told those at a Senior Management meeting that he and the VP Finance had approached the President with what he described as a "big bomb" and one that he considered would result in "changing the culture" (Notes, January 8). He advised that they had talked to him about putting a freeze on borrowing for the capital projects, setting aside $8.5 million to enhance the plant, acquire high technology and management information systems, engage in special projects such as the Emergency Department renovations and purchase capital equipment. Whatever was left over would go to such things as the OR Project. He described capital borrowing in this economic climate as "indefensible" and he could not see paying out interest when they couldn't service the existing buildings. He wanted to get the reaction of the senior team and emphasized that this was not a "hidden agenda", as he had discussed it with the President. When asked, the VP Finance explained that there was about $3 million in loan debt that he hoped to pay off by March. The VP Finance said that Board members were "gun shy" and reported that the Chairman of the Finance Committee had called recently to ask: "You don't have shovels in the ground?". The EVP said that they would have to go to the Senior Medical Committee with the idea of "no borrowing" and
someone noted that if there was no agreement, they would be "up the
creek" (Notes, January 8). A VP asked: "Who loses?" and another
answered: "The President and the Research Centre". The EVP said
that it was a question of timing and that redevelopment would take
place, but at a slower pace. A VP said: 'We can't keep ignoring
the plant or there will be big trouble". The EVP said that it was
"just not the way to go out and borrow. God knows what will happen
in the next few years" (Notes, January 8).

The President responded to Board and Senior Management
pressures by drafting a three-year business plan that would address
operating and capital issues and guide Riverview's spending
decisions for the medium-term. In the draft business plan, he made
assumptions about POEs and decreased the scale of the OR project to
"in situ" renovations (document 157). In presenting the draft plan
to Senior Management, the President acknowledged that there were
probably things missing, but that he wanted feedback and that
everything had to be on the table so that they didn't "get caught
with a million dollar item" (Notes, January 27). He said he now
thought that they wouldn't get $5 million for the OR Project and
that perhaps they had to "forget about OR renovations" except for
fixing safety items and spending some more money on equipment. He
implied that he had heard this view as a possibility from surgeons
and others connected with the OR. He said that his draft plan was
a "first cut" and that the figures were "uncertain". The capital
projects list contained a $6 million estimate for the OR project
and an estimate of $.5 million for step-down units. The grand
total for capital spending was $45.2M or $15M per year. He said that there were so many things "floating around" that they had to make some decisions, as the Board Chairman wanted the plan brought to the March Board meeting, once it had been discussed with physicians.

Most of the VPs, the Chief of Staff and the President of the Medical Staff were present and all of them gave the President feedback on the draft plan. The major concerns related to capital were that there were key items missing from the list and that the OR issue was a "minefield," as the amount was far less than half of the planned project and a previous attempt to merely renovate the ORs was "a disaster" that had caused a major disruption in service (Notes, January 27). The President agreed that they needed go back over the OR project and when he asked how to go back to the nurses and surgeons involved, he was told: "wearing armour". Another VP said that the greater concern should be the trustees and the President agreed, noting that the former Chairman of the Board strongly supported the OR Project. The President expressed frustration saying that there had to be some decisions made in order to make resource allocation decisions---"Do they want an MRI or an OR?" and "What do doctors want?" There was some discussion about the need to bring physicians into the discussion and it was agreed that there was a need for a weekly Council Meeting that brought the appropriate people together in a forum chaired by the President (Notes, January 27).

The President presented his draft business plan at a meeting
of the Senior Medical Committee, explaining that he wanted to do things "using our own capital". He said that the MOH approval process was protracted and frustrating and that it took 48 months for approval of anything, which was "a nightmare". In his draft business plan, the President had written: "I expect that the following programs will be our 'Programs of Excellence'" and he had listed five areas: the area for the Clinical Centre and four other areas that were foci for the Research Centre. Two areas that had been part of the "four foci" were mentioned: "regrettably [these] may have to be postponed as 'Programs of Excellence' for at least three years" (document 157). One of these areas was related to the Chief of Surgery's expertise and an area that was used to justify the decision on the OR Project. When asked by a physician how the document related to the strategic plan, the President described it as a "corporate" document or a focus document. He expressed frustration with the process underway to identify POEs and said: "if we sit and wait for a lot of people to make a whole bunch of decisions, things that need to be done won't be done" (Notes, January 29). A Division Chief said that the business plan went around the strategic planning process and that there was "no forum for deciding issues". He described the business plan as "supplanting" the strategic planning process.

The Chief of Surgery said that he wasn't talking much because he had already been in a meeting with the President about this topic. He emphasized that the difficulties in the OR were more than just a few safety standards, but it was clear that
they weren't going to get the $5 million grant, so that they could only do one major project. He told them: "the delay of the OR is wrong". The President said that "the trustees are the major problem" as the OR Project was their first priority. If he didn't do something regarding safety for the ORs, he wouldn't be able to do anything else. He described himself as being "under pressure" from the Board and from the medical staff, who were "asking for things". He said that some of the planning had been done under wrong assumptions and that the signals had changed with regard to funding since the original meeting three years ago at a retreat. The President insisted that the medical and administrative staff had to meet to "make some decisions" (Notes, January 29).

At a subsequent meeting with senior medical staff, VPs reluctantly acknowledged that they were uncomfortable about what was happening to the strategic planning process and the President's business plan. The EVP said that he wanted to discuss this further with the President before anyone raised it, as was being suggested, at a Board Strategic Planning meeting (Notes, February 15). In the meantime however, the President of the Medical Staff had initiated a Board/Medical Liaison Committee shortly after the argument over the business plan (document 166). When the President reviewed the agenda for this meeting with senior managers, he noted that the strategic planning process was one of several items to be discussed. The President of the Medical Staff explained that the meeting was set up to "forestall crises," such as one in Radiology, that occurred due to "lack of communication" as well as other
"matters of sensitivity and controversy". The President reported that he would be making "a concerted effort" on the strategic plan over the next few months and would "set the business plan aside while we get priorities straight" (Notes, February 5). Later, there were reports that at the Board/Medical meeting, surgeons had told Board members that they could accept delay of the OR Project until sufficient funding was available for the full project, but that they did not believe that the Research Centre project should proceed ahead of the OR Project (Notes, March 3).

Related to strategic planning were the inter-hospital discussions on rationalization of hospital services. Although a draft report had been developed by a CEO-dominated committee, there were reports that physicians were alarmed about the proposals in the report (Interview 13). The Chairman of the Board had insisted that the report not be released until the Boards of key teaching hospitals met to discuss the contents so that decisions were not the result of "deals being cut by CEOs" (Notes, February 4). In early March, the President brought the draft rationalization document to a meeting of the Senior Medical Committee for discussion and pressed for an indication of what physicians thought about the "examples" of how services might be shifted among hospitals (Notes, March 4). When senior physicians resisted discussion of specifics and wanted to focus on "principles" and definitions of rationalization, the President reacted with frustration, saying he had to go to a meeting with other hospitals and he had "no idea of what to say" on behalf of Riverview. He
wanted to be able to tell other hospitals "what we want" and he had been trying to get some indication for several months. A physician responded by arguing that such decisions could not be made "by having an executive meeting once every four months" and expressed concern about the President's suggestion that he and two Division Chiefs meet to prepare for the Rationalization Committee meeting. The physician preferred to discuss the issue at a Senior Medical Committee so that it would not look like "another back room deal" (Notes, March 4).

7.2.3 Revision of the Capital Budget

In November, the Finance Committee had identified the need to clarify financial policies that would guide capital spending and had asked for a review of the capital plan, given the economic constraints for Riverview (Notes, November 19). In December, the Finance Committee advised that no capital project should proceed until all projects were re-evaluated as to priority and that capital spending should reflect strategic directions that would be clearer in several month's time (Notes, December 17; document 153).

Although identification of items for a comprehensive plan began in early December, a revised proposal was not ready for approval until June. Resistance to decision-making on capital items as described earlier, was followed by several months of preoccupation with finalizing an operating budget proposal. Although comprehensive capital planning did not resume until the operating budget was settled at the end of March, two capital projects were brought forward for consideration in the meantime.
A decision was made on the heliport project at the end of January when the Board approved funding of $300K for preparation of the site. The local area politician on the Board reported that the neighbourhood group had been told that the MOH had requested and would fund the project and that there would be 100 flights a year. She objected to the proposal as the estimate of flight per year was now higher and it seemed as though Riverview was paying for the heliport, not the Ministry (Notes, January 30). The President explained that the Ministry had revised its flight estimates and that the Ministry had originally said that they would fund it. He described the heliport project as "in keeping with the strategic plan" and that "we and the medical staff" support it. Members of the Finance Committee and other Board members spoke in support of the motion, noting that while they would like Ministry funding, they believed that they should go ahead with the project. One Board member described it as a "service and leadership issue" and another Board member agreed saying that it had been discussed at the District Health Council as a priority so, "Why should the community suffer?". The motion was carried (January 30; document 183).

Although a comprehensive plan was pending, a decision was made on one of the priority projects, the Clinical Investigations Unit, when the Board approved tenders for the unit (Notes, April 30). In January, the President had suggested scaling down this project by moving the CIU to an unused nursing unit rather than using shelled in space. This approach would reduce the cost of the project and was supported by senior management and senior physicians. When MOH
approval of the project was received, the Finance Committee agreed to issue tenders for furniture and equipment (Notes, February 17). Although one Board member expressed concern that such a decision should await the outcome of strategic planning, the Chair of the Finance Committee pointed out that the CIU was a focus for the Research Centre and that the decision would not necessarily mean that CIU would be selected as a Program of Excellence (Notes, April 30).

During February and March, senior managers were preoccupied with finalizing the operating budget for the next fiscal year and tensions were high as two of the municipal politicians on the Board pushed for disclosure of information on executive compensation. The President told senior managers that Board members who were up for a second term and who were appointed by the City, had been scheduled for unprecedented interviews to consider renewals (Notes, February 17). He reported that issues raised during the interviews included one of "withheld information," such as changing the number of helicopter flights. He said that some Board members thought that "we are dishonest" and that the "Board [was] left in the dark". Reference had been made to an earlier problem with the Riverview community and it had been said that the hospital was "arrogant" with neighbours. The President reported a belief that some Board members were "getting back" at other ones who were not supportive on the parking issue the previous Fall and as a result, several Board members might not be reappointed. He told senior managers that they should be careful with accuracy and not change
numbers and that he had made a mistake on this regarding helicopter flights and had appeared to be hiding something. He also noted that there had been an agreement that there should be no capital expenditures until the strategic plan was settled (Notes, February 17).

Following the insistence that the strategic planning process should precede decision-making on a new capital plan, the President and the Senior Management Team, along with the Director of Planning, began to compile information and develop options for capital items (Notes, February 5). They discussed options for the OR project that ranged from essential upgrades for $1.4 million to a full project at $25 million. Items on an initial list of projects, including an OR project at $6 million, totalled more than $76 million and these were only rough estimates. When the VP Finance estimated "cash flow" and fundraising revenue at $13 million per year, all participants seemed somewhat overwhelmed with the choices required. The President and EVP noted that a strategic plan was critical, if they were to consider POEs in planning budgets (Notes, February 5).

At a March meeting, when the Finance Committee looked at the proposed operating budget for the coming year, the VP Finance said that they still had to do the capital plan and dovetail it with the strategic plan. The Vice Chairman of the Committee said he was concerned about plant maintenance not being addressed as he had noted that it seemed to be cut "year after year" and it "is nowhere the last three years". The VP Personnel said that they were
developing a three-year plan and the VP Finance noted that they had included an increased amount for maintenance in the operating budget. The EVP said that more for maintenance would have to be included in the capital plan and a Board member agreed, cautioning that the more you delayed, the more expensive it became (Notes, March 17).

Although decisions on the heliport and CIU projects had been taken before the comprehensive plan was in place, the VP Finance considered these to be relatively small-cost projects (Notes, April 13). Of greater concern was the list of growing capital projects, some from the past that had been "promised", but ignored, during the focus on the priority projects and on those that had emerged on an urgent basis. The VP Finance and the Director of Planning had been meeting to identify "carryover" projects from last year and a presentation was given on these to the Finance Committee along with proposals from the VP Finance on "principles" for capital planning (Notes, April 21). The principles were: no borrowing (he mentioned that they had authority for a $20 million limit but they did not believe they should use this); spending plans restricted to 75% of estimated cash flow; individual project approval by the Board; and creation of an annual discretionary fund. The Chair of the Committee agreed that they did not want to use the borrowing limit.

Participants at the Finance meeting seemed distrustful and annoyed that little information on the financial status of projects was available and that new items were being proposed. A new Board
member pressed for further information on the amount already spent in the list of "projects in progress" and when the VP Finance explained that they were trying to redo estimates on these and it was difficult to give the remaining amount at this time, the Board member replied "I don't believe that" (Notes, April 21). When the President presented four items for information that would be brought forward in future, the Chief of Staff reacted to an item for laboratory renovations for a Research Centre scientist, saying that it had not been mentioned before and was "a shot from the shoulder". The Chairman also reacted to another amount of over $1 million for the Research Centre (for completion of the second phase) and noted that some physicians did not believe the Centre project should precede the OR project. The Chairman said that no further monies should be spent pending decisions on capital plans and that in her view, even if things like the heliport were approved, "all bets were off" until they established priorities. She expressed concern that "work would start on the heliport" and she didn't want a "shovel in the ground" until decisions were made. Later that day, she sent a letter to the VP Finance giving explicit direction that there should be no further borrowing and no further expenditures (document 241).

A re-emerging issue was that of capital expenditures for parking lots, as the Fall debate about parking problems had led to the establishment of two committees. Based on an agreement with a neighbourhood group and City officials, a technical committee was set up to look at an existing parking lot and a City senior
management committee was established to look at the reports and options presented by the technical committee (Notes, January 28). The President reported that an agreement had been worked out based on recent discussions with the City and the neighbourhood on parking (Notes, April 13). The agreement meant that Riverview would have to spend more than $600K and there would be a loss of parking spaces. Therefore, the President wanted the Director of Planning to go back to these groups with several new ideas. These ideas involved "going underground" to create parking spaces beneath an existing lot and building a new lot in another location, for a total cost of $4 million. The President commented that there was still the "old connotation of [Riverview] having something up its sleeve".

He asked for the advice of VPs on the capital spreadsheet and asked if they should "borrow or pay up front" to proceed with such a project. The VP Finance cautioned that the Finance Committee would not want to borrow and that they should develop a three-year capital plan, holding back 20 to 30 per cent in reserve so that "we make sure we don't fall into a borrowing position". The President wanted to get approval for the costs of the parking agreement with the City and a list of capital projects to the Finance Committee next week. When the VP Finance noted that the Finance Committee wanted a warning and complained about being asked to approve things without a notice, the President and Director of Planning insisted that there was a "political problem" as they needed to go back to the City to ensure that the parking lot proposal was consistent
with the official city plan. That plan was currently being revised based on the agreement that had been worked out (Notes, April 13). To add to these problems, the President was visibly concerned about personal safety, as several death threats had been received and investigators believed that they came from a hospital employee who was worried about job loss (Notes, April 21). Additional security measures were taken when additional threats were received (Notes, April 21).

At the Finance Committee, the Director of Planning presented the parking issue explaining that an alternative to the proposals in the official city plan, which would eliminate one of their current parking lots, was being worked on by the City, the neighbours and the hospital. He presented three options, with the first one being the plans reached through an agreement. The second option involved underground parking and option three was the addition of a lot to increase parking spaces. Board members asked questions about revenue from parking and title to the land involved and also made alternate suggestions. No mention was made however, that the agreement worked out with the City and neighbours did not include the last two options. The Finance Committee agreed that they would look at the revenue implications at the next meeting and include the underground option in the capital plan considerations (Notes, April 21; document 224). This lack of clarity about the proposals generated anger at the subsequent Board of Trustee meeting when the Director of Planning presented the parking lot proposals. As they discussed their concerns about the proposal,
the local politician on the Board said that underground parking had never been discussed with the community or the working group and that it would increase the traffic. The Chairman immediately ended discussion, saying that he thought that proposals had been agreed to and it was clear that they had not. He said he did not want to waste time discussing the issue at a Board meeting, until Riverview went back to the working group to clarify items (Notes, April 30).

The President chaired a series of four Capital Planning meetings attended by the Senior Management Team, representatives from the Research Centre (the Senior Vice President returned to work and joined the Assistant Director at the last three of these meetings) and the President of the Medical Staff (Notes, April 29, May 6, May 14, May 21). At the first meeting, the President and the VP Finance engaged in some restrained verbal sparring with regard to the implications of the cash flow forecast. The VP Finance described the forecast as "bullish" and the President said: "we have been bullish for the last 14 years" and hadn't had deficits. The VP Finance agreed, but pointed out that they had received substantial increases in revenue in the past two years that would not be forthcoming this year. When the VP Finance proposed that 25% be held in reserve each year and the amount then available for each of the five years in the plan, the President noted that any other money was "borrowing". The VP Finance immediately emphasized that there could be no borrowing in this environment as it "would not be prudent" and he "wouldn't advocate borrowing". When asked by the VP Finance, there seemed to be
agreement among participants on the proposal of a reserve, a balanced budget and no borrowing. The President commented: "I like that reserve" (Notes, April 29).

The Director of Planning gave participants two versions of a list of capital items, both of which totalled more than the funds that were available (document 240). Participants identified missing and underfunded items and identified the OR project as a major problem as the cost in the scaled down version was below the amount last approved by the Board. The EVP noted that the OR project had to be sorted out if it was the first priority as everything else revolved around it. They agreed that missing items had to be added to the list and that the OR project had to be "revisited" with the OR planning group before the next meeting (Notes, April 29).

A meeting of the OR planning group was held that lasted several hours, with the EVP negotiating with the group, as the President only attended briefly. At the meeting, the Chief of Surgery expressed anger about redoing the numbers several times for the OR project and he wanted there to be a commitment before they were reworked again. The EVP said that the $5 million grant from the Ministry would not come through and they had to look at other options because they could not do the $25 million version. The Chief of Surgery wanted the ICU and step down units included in any project. Although the mood of the meeting vacillated, it ended on an "up note" with some agreement to look at a project of about $14 million. The EVP later reported that the meeting was "reasonable"
despite the fact that they went from $25 million for the project to half that amount. He noted that there would be fallout if they were unable to do the project (Notes, May 6).

Despite the scaling down of the OR project, the two versions of the capital spreadsheet discussed at the second meeting totalled more than the first set had (document 245). Items that had been added or reduced were noted and when the President asked for comments from those around the table, almost everyone argued why certain areas should not be eliminated or reduced. As the lower cost version was still $35 million more than the funding available, the President said that they would have to rework the proposal. The EVP emphasized that the proposal had to be "orchestrated right" as there would be significant changes in expectations (Notes, May 6; documents 244, 246).

Before the start of the third meeting, the VP Finance told me that he was going to present material on the revenue side for capital projects (Notes, May 14). He told me that "people could talk about what they wanted to spend the money on", but that he wanted to talk about where it would come from. In his presentation, he said that in addition to what they had available for capital, they needed another method of bringing in cash as it seemed as there was just enough to maintain what they had, without any provision for "growth" or "change". As they probably were getting as much as they could from fundraising, perhaps they should "restrain operating dollars" in order to create a 2% surplus. He said they would have to decide how to allocate and gave some
examples of criteria that might be used: patient care, safety, replacement, new technology and efficiency. He believed that they would have to start thinking in terms of "98-cent dollars" in allocating the operating budget if they wanted to build for the future. He noted that the climate had changed and that industry had to plough money back into their organization out of profit, although he recognized that people might decide that they couldn't take funds out of operating to finance capital growth (Notes, May 14).

The President informed participants that the EVP had a presentation on how to approach the capital plan. The EVP proposed that $3 million be allocated for capital equipment with a similar fund of $500K for the Clinical Centre. He then presented a list of "initiatives in progress" with "committed funds" for 1992-93 that they could either go ahead with or modify. The list included CIU, the heliport, planning costs for the OR, renovations and plant improvements. Beyond that list however, they should only consider further spending in 92/93 in terms of criteria. He said that secondly, any planning for 93/94 should be delayed until: programs of excellence were determined with a capital plan for each; university strategic planning and rationalization was finalized; transfer payments from the government for 93/94 and 94/95 were clearer. He said he did not think it made sense at this point to tie up capital funds, given the uncertainties. The President seemed to like this idea, but asked for comments. A number of concerns about items missing from the EVP's list were mentioned and
they decided to compare his list (document 248) to Version C (document 247) prepared by the Director of Planning following the last meeting. Missing items were then identified and it was agreed that the EVP 's list would be circulated to everyone prior to the next meeting (Notes, May 14).

At the fourth capital planning meeting, participants formulated the following recommendations:

The Operating Room/Surgical Suite is the #1 priority. $500K will be allocated in 1992/93 for continued planning. Capital monies for the operating room will not be required until fiscal 1993/94.

Any additional capital expenditures for 1992/93 will be used for projects/equipment considered "critical".

In order to determine this, the following suggested criteria may be used:
- patient or employee safety
- quality of care
- availability of alternatives
- revenue or cost impact
- level of service
- legislative requirement

(document 249)

Participants generated a list of 1992/93 Capital Projects. The list included the usual capital equipment fund plus one for the Clinical Centre and a list of "initiatives in progress". The list included the CIU and heliport projects and a reserve fund of $500K, but no major redevelopment projects beyond planning costs for the OR Project and a similar amount for renovations in the Research Centre (Notes, May 21; document 249).

The list of projects was reviewed by a group of senior administrators and senior physicians at a retreat in mid-June, but the list remained essentially unchanged. Spending projections were
just under the projected funds available for a five year period, but the plan did not contain some of the major items from the previous plan. Instead, these were included in a statement of "projects to be considered" and totalled almost $30 million. Items included x-ray equipment, an MRI, a lithotripter, parking projects, major labour and delivery renovations and additional maintenance projects (document 253 A).

At a MAC meeting, the VP Finance presented what he described as a "full disclosure document" and mentioned that he often heard people say "we don't know if we're getting all the numbers". He emphasized that all the numbers were in the documents. He pointed out that the projects listed for 92/93 were not major ones and that they were "fix up projects" and maintenance (June 18, lines 97-146). He told physicians that he wanted to make "a pitch" for decreasing operating dollars in order to have money for capital. He said that they would have to think about operating on 97 or 98 cent dollars so that they would have an "in house ability to fund capital requirements" (Notes, June 18).

One physician asked if they could look at mechanisms to encourage people to operate on 98 cent dollars as there were no incentives to do so and historically, if they saved, it did not mean they got what they needed as a reward. The VP Finance replied that as long as there was a corporate decision about priorities, incentives could be looked at, but everyone had to understand that if they freed up $5 million through savings and the corporate decision was to buy an MRI, that the money would go to the MRI, not
to individual departments. He said that the next year however, the department might get capital dollars if it was the next priority. When the question of incentives was raised again, the VP Finance again noted that decisions on priorities had to be made at the corporate level.

Several physicians asked about the process used to make decisions and if there were "appropriate presentations" made to those who did decide. The President explained that there had been a series of meetings and a final retreat with senior administrative and medical staff. The Chief of Staff confirmed this and when asked how much physician input there was, he reiterated that there had been three meetings and some members of the Senior Medical Committee had been invited on three occasions. He said that the process was not perfect and was "a scramble", but noted that it was the first time they had put out a document like this. Several physicians complimented the VP Finance on his presentation and one said that it was the first time they had received this much information. As there was no quorum, the Chair said that they would note the motion's mover and seconder although this was not an official vote. When he expressed concern that there were so few physicians at such an important meeting, a member said that they discuss so many unimportant things and "predigested" items, that attendance at MAC was poor (Notes, June 18).

When the Finance Committee met to consider the proposal for capital projects, the Chairman of the Board and some fairly new members of the Board attended the meeting, although there was not
a quorum of regular members as new Board members had not yet been assigned to committees. The Chairman introduced the item on capital projects and noted that the "OR has got to be the number one priority" for major capital projects. The VP Finance gave a presentation that included information on income for the past three years, noting that $13 million in debt had been paid off. He said that they should "start thinking about changing the culture" by considering planning for 98 cent dollars so that they could build a fund for capital projects. He explained that business has to finance projects out of profit and that the hospital has few ways to get a profit without looking at reduction of operating costs (Notes, June 19).

The VP Finance presented the list of projects in process and the Director of Planning described the progress on each one. With regard to new projects, the Director reported that they had been reviewed by MAC, ranked in groups and discussed at a number of meetings. The VP Finance noted that these new projects were all ones that they could "crank down quickly if money was not available". A new Board member noted that "in general, any projects have to recognize the thrust of the strategic plan" and that most of the proposed list seemed to be for maintenance. He was told that yes, these were maintenance items, although the heliport and the Research Centre renovations related to the strategic plan. When asked to comment on the MAC meeting, the Chief of Staff said that the members were very pleased with the information prepared and provided by the VP Finance. It was agreed
that the capital project list for 1992/93 and a $500K annual equipment allowance for the Clinical Centre would be recommended to the Board. The Chair noted that as a High-Technology fund was a priority for the Committee and as the cash flow projection for 1992/93 was positive, it would be a good time to establish the fund. The Committee agreed to recommend an annual allocation of $1 million to this fund and the Finance Committee would approve expenditures from it. (Notes, June 19; document 256). All three recommendations were approved at the June Board meeting (document 264).

7.3 Capital Budget Outcomes

By the end of the 1991-92 fiscal year, there had been more than $13 million in capital spending, approximately half of which was offset by income from grants and donations (document 253B). Planning costs for the OR project and the third phase of the Research Centre, the capital equipment fund and replacement of an elevator accounted for the largest amounts that were not offset by capital grants. As envisioned in the original five-year plan, loans of more than $9 million would have been required at this point and construction would have been underway on several major projects. At some point, that original plan had been somewhat revised and planned spending for the 1991-92 year was $19 million, with a loan balance of more than $12 million (document 49). By August of 1991, senior administrators realized that spending on major capital projects would be delayed and such spending levels would not occur in the 1991-92 year, nor would the loan balance be
as high as predicted (Notes, September 4). At that time, the President pressed for a balanced budget so that capital projects could proceed and there was still an assumption that further borrowing would occur to enable this.

Decisions about capital projects made during the study period committed the Board to the heliport and Clinical Investigations Unit, but these were relatively small amounts when compared to the OR project and the third phase of the Research Centre. When the capital plan was revised, based on a comprehensive review of projects in process and past approvals for future projects, a five-year plan with an estimated cost of more than $78 million was approved. Although it was agreed to commit to spending for the 1992-93 year only, the five-year plan assumed a continuing commitment to the OR project, scaled down by half the amount that had been agreed to at the beginning of the study period, step-down units and ICU, completion of the full second and third phases of the Research Centre expansion, the annual capital equipment fund and a new capital equipment fund for the Clinical Centre, the heliport and an additional cooling plant.

New projects in the five-year plan included more than a million dollars for each of the following projects: parking, nursing station renovations and physical plant improvements. There was also a commitment to a reserve fund of half a million dollars per year. Projects that were "on hold" were included on a list that totalled approximately $30 million. This list, titled, "projects to be considered", was composed of major x-ray equipment,
an MRI unit, a lithotripter, cooling of patient units, a complete labour and delivery project, major parking projects and a number of renovation projects. No commitments were made to these projects in the five-year plan, but it was noted that they could be considered, if funds became available.
CHAPTER 8

THEMES IN ALLOCATING THE CAPITAL BUDGET

In this Chapter, I discuss themes that emerged in the analysis of data presented descriptively in the previous Chapter. Themes in capital budgeting at Riverview are discussed with reference to the literature.

8.1 Roles, Goals and Preferences

As with the operating budget, the senior administrator group co-ordinated formulation of a proposal for the capital budget. As the senior administrator responsible for long-range planning, the President carried the major responsibility for the capital budget, particularly with respect to capital financing, gaining approval for major capital projects and forwarding major spending proposals to the Board. The President relied on the Director of Planning for detailed work on proposals and projects as well as on the VP Finance for estimates of capital funding, but during the initial field work period, he seemed to work somewhat in isolation from the Senior Management Team with respect to capital matters. Only later, when the Finance Committee refused to approve capital spending without a comprehensive plan, did he bring senior managers and senior physicians together in a planning forum.

Prior to that time, the Senior Management Team's role with respect to capital expenditures was confined, for the most part, to review of the capital equipment budget and decisions on priorities for renovations. While these items were important in terms of the ongoing operations of Riverview, they represented a relatively
small proportion of proposed capital spending for any one year, with the major planned expenditures devoted to the capital redevelopment projects and projects carried over from previous years.

The President clearly championed the goal of capital redevelopment at Riverview and thought that strategic change was necessary if Riverview was to position itself for the major changes he foresaw in health care. He was willing to make relatively quick and substantial changes in Riverview's activities and services to achieve the goal of financial stability, but his ultimate goal was capital redevelopment, a goal he saw as consistent with strategic change. He expressed a sense of urgency about proceeding with redevelopment projects, borrowing money if necessary to finance these. He seemed to prefer the Research Centre expansion project, seeing it as essential in securing Riverview's position as an academic health centre. His proposal to drastically reduce the size of the OR project to one of safety renovations suggested that he did not view that project as important as the Research Centre expansion.

In contrast, the Senior Management Team focused on those goals that promoted stability in Riverview's finances and operations. The Team resisted rapid operating budget reductions that might have a disruptive effect on hospital operations in order to balance the budget and proceed with capital projects. Unlike the President, members of the Senior Management Team did not express a great interest in the pursuit of strategic change;
rather, they worried about the impact of such changes on direct care services, as they anticipated that increased allocations to research and programs of excellence would put additional pressure on the operating budget. They also advised the President that Riverview should not borrow funds at this time to achieve redevelopment goals. While the President saw his role as guardian of Riverview's future, the Senior Management Team acted as guardian of internal operations. According to Wildavsky (1986), a knowledge of role is more important than a knowledge of individuals in understanding most budgetary decision-making:

Yet we all know that it does matter who (by ideology, class, party, personality) occupies these positions. ....Nevertheless, I believe that knowing the role attached to an institutional position almost always is more helpful than any other bit of information. If one is mainly interested in figuring out the likelihood of the latest move in a specific situation involving expenditure, knowledge of the personalities and predispositions of the key decision makers is essential. If one is looking for the most powerful predictive variables over the largest number of instances, role will beat personalities hands down. When this is not true, it is a sure sign that something is very wrong with either the observer or the observed (p.3).

This division of roles meant that the President and the Senior Team responded to different pressures and the preferred goals of the two diverged in several respects. While the Senior Team experienced greater pressure from the operating core for maintenance, renovation and increased salary costs, the President was under pressure to pre-empt external threats to Riverview's future as a lead academic health sciences centre and to proceed with major construction projects in the midst of economic constraint. While the President's language emphasized "progress",

"intellectual growth", and "patient care advances", that of the Senior Management Team emphasized "appropriate", "prudent" and "conservative" approaches to avoid "disruption" and "maintain services".

Senior physicians who were active in discussions of the operating budget were also involved in capital budgeting. In addition to these senior physicians however, the deputy director of the Research Centre also became involved in the absence of the Senior VP, as one of the priority projects was an expansion of that Centre. As with the operating budget, physicians played a role in reviewing capital proposals and budgets and coming to an agreement on these prior submission to the board. Prior to the study period however, several senior physicians had announced that they would not approve capital spending until Riverview had a formal strategic plan that had been developed with the involvement of a broader representation of the medical staff. Although the two most vocal physicians had an interest in the priority capital projects that had already secured board approval, they did not agree with the four strategic "foci" developed earlier by a small group. As Chiefs of Divisions, they were concerned about the reaction of medical staff if strategic decisions were perceived to be "another back room deal". By threatening to withhold their approval of capital spending, they had the ability to delay capital redevelopment at Riverview.

Senior physicians supported the goals of fiscal viability, maintenance of hospital services, strategic change and capital
redevelopment, but it was more difficult to detect a group consensus on which goal took priority in decisions. Those senior physicians who were most involved in research and university activities were the most vocal in support of strategic change, research allocations and capital expansion of the Research Centre. They argued vigorously for the strengthening of Riverview as an academic health sciences centre, with fewer but more specialized services, state-of-the art patient care and a greater emphasis on teaching and research. They wanted to move towards resource allocation that was consistent with shifting Riverview away from a community hospital model towards a stronger teaching hospital model. They talked in terms of "intellectual capital", "excellence", "knowledge-based practice" and "exemplary care".

While most senior physicians agreed that such a change made sense, some of them were in roles that were more oriented to the provision of medical services than to the teaching and research mandate of Riverview. For example, the Chief of Staff had responsibilities for a broad range of existing medical services and the President of the Medical Staff represented all physicians at Riverview, many of whom were non-GFT physicians without strong ties to research and teaching. Some non-academic physicians were threatened by the potential elimination of their specialty at Riverview so that more resources could be allocated to research and programs of excellence. These physicians tended to support maintenance and renovation projects in the capital budget and emphasized "community needs," "quality of patient care" and
"responsibilities to the community".

In addition to physician subgroups with different preferences, a number of senior physicians seemed to suffer from internal conflict over decisions. Sometimes, the same physician would advocate a balanced budget so that capital development could proceed and at a later meeting object that budget cuts would reduce the quality of care and level of Riverview's services. As a group, senior physicians seemed to be the guardians of everything which, in effect, made it difficult for them to be the guardians of anything in decision-making.

Members of the Board of Trustees, conscious of their financial governance role, emphasized the goal of financial viability and pressed for a balanced budget, "efficiency" and "business decisions". They referred to the debt problems of another hospital in the province and thought that such a situation reflected badly on that Board's performance in financial governance. Board members also viewed their role as protecting the public interest and they emphasized the goal of maintaining services for the community. The success in achieving a balanced budget and financial stability could be measured, but it was more difficult for Board members to predict the effects on services of such decisions as hospital bed closures and a pre-admission unit. They searched for answers to such questions, asking senior administrators how proposals for bed closures related to the closures in other hospitals and the resulting impact on community services. They drew some assurance from the requirement that medical staff had agreed to proposals,
but their immediate measure of success in maintaining hospital services was the absence of negative media stories and public complaint about the quality of or accessability to Riverview's services. Similarly, they sought to ensure that strategic change did not bring about gaps in services in the region. In sum, Board members saw themselves as guardians of the bottom line and the community interest.

Board members supported the goal of capital redevelopment, but they were unwilling to pursue these at the expense of fiscal stability. In general, there was a Board consensus that the OR project was a priority, a consensus rumoured to have developed because of lobbying and "scare tactics" by surgeons several years earlier. However, they were alarmed by the growing cost of that project, so they halted spending and borrowing until a comprehensive plan was put before them and they were assured that Riverview could afford to embark on an "ambitious" capital program.

The roles of Board members on committees did seem to influence their support of other capital proposals. For example, the Chair of the Board's Strategic Planning Committee spoke in favour of allocating funds to capital projects that he viewed as consistent with strategic directions and providing Riverview with a "competitive edge". However, even this Board member thought that financial viability was a priority and was reluctant to approve borrowing and spending without more information. An exception to Board consensus occurred when the capital development goals of Riverview had an impact on the local community and local
politicians on the Board were in conflict with their colleagues.

The Board exercised more control over capital allocations than operating decisions and they seemed to do so for a number of reasons. First, the focus of Board members on the bottom line was reflected in their concerns about Riverview's growing deficit, debt load and increasing costs of the OR project. Board members were in a position to block capital expenditures as these were generally forwarded to them one item at a time for approval, whereas blocking a total operating budget was less feasible. Second, there was a legacy of mistrust about administration proceeding with unapproved capital projects and board members were cautious about approval of these. When they perceived that there had not been sufficient consultation, that they were being rushed, or that process was not being followed, they refused to make a decision until issues were explored and resolved. Third, board members did not feel comfortable with their knowledge about the state of capital finances and wanted the total picture with respect to capital projects, a picture that ought to address their priorities such as the OR project, emergency renovations and maintenance. Last, Board members saw themselves as having expertise with regard to the business decisions that were required with large capital expenditures and expertise with regard to establishing strategic directions in a way that would give Riverview a "competitive edge".

8.2 Deteriorating Relationships

As the President was the lead person for the capital budget he had to formulate proposals and secure approval of these from senior
physicians and the Board of Trustees. In order to advance his proposals, he also required the support of the Senior Management Team. Over the period of field work, the President found it increasingly difficult to secure the support of the Senior Management Team for progress on capital projects. Members of the Team privately tried to convince the President that Riverview should not borrow to finance capital projects and later, expressed these views openly in meetings and advised that capital projects should be delayed in favour of maintenance and renovation projects.

During the period of field work, the relationship between the President and the board and physicians deteriorated considerably, with repeated confrontations over process issues related to capital items and strategic planning. A certain degree of distrust of the President was evident at the beginning of field work as Board members suggested that in the past, the President's enthusiasm for capital projects led him to proceed without Board knowledge and approval. As they were wary of this tendency, Board members insisted that the President go through all the steps of the normal process of approval. If the steps were not followed, approval was blocked, as when the Chairman of the Board tabled an agenda item on heliport funding that had not been discussed first by the Finance Committee and stopped discussion on funding for a parking project at a Board meeting when it became clear that committees established to discuss parking had not been consulted on the proposal.

Conflict between the President and senior physicians focused on strategic planning and capital projects. The President made
three attempts to get physicians to identify likely programs of excellence so that he could discuss rationalization of services with other hospitals as part of the university planning process. Physicians, who were aware of the potential impact of rationalization on medical staff at Riverview, resisted identifying these prior to the decision-making underway as part of Riverview's strategic planning process. They insisted that this planning process should precede any discussion of rationalization and decisions on capital plans. The President's suggestion that the OR project should be substantially scaled down led physicians to approach board members for a joint meeting, a meeting that forced the President to abandon his business plan and proceed with strategic planning.

Whereas the Senior Management Team was successful in generating operating budget proposals that gained approval, it was only by finally drawing on members of the Senior Management Team, particularly the EVP and the VP Finance, that a proposal for the capital budget was generated. In the past, the President seemed to have been able to proceed with capital expenditures on approved projects, however, senior physicians and Board members blocked such spending and insisted on "following process". The approved capital budget was not one that fully reflected the President's views on capital spending and differed somewhat from what he had envisioned in his draft business plan, especially with regard to the speed with which capital projects would proceed. External factors, including economic changes and funding restraint by the provincial
government and proposed changes in city regulations also hampered progress on planned capital projects.

The President had difficulty in mobilizing his formal power to achieve his vision of the future, in part because Riverview, as a teaching hospital, was characterized by a weaker system of authority than that found in "machine bureaucracies" (Mintzberg, 1983). Changes in the senior administrative structure had brought changes in senior administrative roles and positions. The President became more external in focus with the addition of an EVP as the lead person for internal operations. As the President increased his focus on capital projects, external relations and long-term planning, his role as the "peak co-ordinator" of divergent interests and activities diminished, to a large extent falling to the EVP. Mintzberg (1983) notes that much of the literature on organizations reflects an assumption that the Chief Executive Officer is able to utilize a "system of authority" to integrate the goals of those to whom he delegates authority with his view of the organization's goals. This assumption is consistent with single rational actor models of decision-making, including those models of hospital behaviour that explain decision-making in terms of the individual preferences and goals of the top hospital administrator (Lee, 1971; Wittrup, 1975). Preferences and goals however, are linked to roles and at Riverview, the CEO's role emphasized the future, in terms of capital projects and strategic planning, while responsibilities for shorter term operational planning and management were delegated to the EVP and Senior
Management Team. In addition, his internal and external conflicts
grew in number, so that he did not forge alliances with senior

Thus, in the Professional Bureaucracy only the politically
astute chief executive is able to effect strategic change. He
pushes it along slowly, using persuasion, negotiation, and
occasionally some interpersonal manipulation, exploiting
whatever informal and formal power he has. Above all, he
knows how far and how fast he can push each issue. The
autocratic CEO drives the Meritocracy toward Political Arena
as the professionals resist him; the weak one becomes the
errand boy of the professionals, securing their funds and
maintaining their external relations, while avoiding internal
issues. Only the one with political finesse leaves his mark
on the organization (p. 404).

8.3 Capital Budget Components and Decision Processes

Decision-making about the operating budget had consisted of an
essentially orderly process of deciding on parameters, building the
budget plan within these guidelines, and submitting the plan to
physicians and the board for approval. The process of developing
a capital budget was quite different. This budget had several
components—a capital equipment component, a minor renovations
component, and a major projects component that included priority
capital projects, ongoing projects, major renovations and major new
or upgraded technology. With the exception of the capital
equipment component, responsibility for formulating proposals and
making decisions seemed ambiguous, the timing for decision-making
was ad hoc and the process of developing an annual capital budget
for 1992-93 was fragmented and protracted, in part because no
comprehensive budget seemed to exist for the current fiscal year.
8.3.1 Capital Equipment Budget

Development of the capital equipment portion of the capital budget was an established process that occurred at the same time as development of the operating budget. Departments submitted requests using prescribed forms, following written guidelines. A capital equipment committee, chaired by a member of the Senior Management Team and composed of middle managers and physicians, reviewed requests and used pre-established criteria to set priorities, asking departments for presentations or further information if justifications were unclear. Most of the items in this budget were for new or replacement medical or office equipment, but this budget did not include major medical technology. The limit for the equipment fund had been established by senior managers and although demands exceeded available funds, the process seemed acceptable to all groups and the committee's recommendations were accepted by senior groups.

It is difficult to tell if this kind of orderly, bureaucratic process for decisions about capital equipment is typical of hospitals, as many studies do not examine budget components, but rather, treat the capital budget as a whole. Young & Saltman (1985) describe a rather informal and ad hoc process in a community hospital, but a process similar to that used by Riverview, in a teaching hospital. They note however, that the teaching hospital, like Riverivew, handled the major capital projects separately, although they do not discuss decision-making on these as a process. Rocher's (1990) study of Quebec hospitals identified the
"rationalization" of decision processes using an organized committee approach to decisions on equipment purchases, but the report did not specify if all types of capital equipment were included in the study. In Deber et al.'s (1994) national study of hospital technology acquisition, most hospitals used an advisory committee composed of representatives of several groups, but there was variation in the extent to which justification forms and standard procedures were used in decision-making. However, in Deber et al.'s study, technology acquisition referred to capital equipment that included major new technology as well as minor capital equipment and the findings were not reported in terms of differences in process for different costs or types of equipment.

Two equipment-related proposals that were unplanned were forwarded to the board during the field work period when the need for a decision arose. These proposals, one for replacement of two CT scanners and one for the purchase of an additional head for a gamma camera, were accompanied by pages of technical analysis and financial analysis. The extensive analysis and the process of decision-making was consistent with Greer's (1984) description of a fiscal-managerial decision model, which she found to be characteristic of decisions for major equipment used for a large number of patients.

Senior managers encountered some difficulties in obtaining approval of the replacement of the CT scans when the President saw the opportunity to obtain MRI equipment at the same time. The Finance Committee refused to make an immediate decision and senior
managers reworked the proposal to highlight the benefit for services to patients, to clarify the financial analysis and to eliminate consideration of an MRI unit. A week later, the Finance Committee agreed to the original recommendation. Board members were uncomfortable with the sudden addition of the MRI unit, as this was major new technology for Riverview, but it clear that they did not like to be surprised by sudden requests for replacement equipment, nor were they willing to be rushed in making decisions. They were therefore given advance notice about a forthcoming proposal for an additional head for a recently-purchased gamma camera and a patient care rationale accompanied the technical and financial analyses. This time, approval was granted by the Finance Committee with little discussion.

8.3.2 Renovations

Renovation expenditures constituted another component of the capital budget. Decisions on these seemed to occur on a sporadic basis, responsibility was fragmented, and decisions were made on the basis of professional judgement for the more minor renovations and sponsorship by senior individuals or groups for the more major renovations.

At one point during the field study, the Director of Planning brought a list of compiled requests to the Senior Management Team to allocate remaining minor renovation funds for the fiscal year. Decision-making was ad hoc in terms of procedures as well as timing, in that accumulated requests totalled millions more than the funds available and senior managers were unclear about the
process. Decisions were made based on the knowledge and judgement of senior managers about priorities in each Division, seemingly without reference to the written justifications for requests.

As funds were insufficient for the larger costs involved in renovations for the Emergency Department, the request reappeared later when the Emergency Department Director reported on problems to the Board's Operations Committee during a trial accreditation review of that department. The Board Committee became a sponsor for these renovations when it urged senior managers to "find" the funds for these renovations, perhaps through donations, in order to address problems that had been reflected in an earlier media story.

Some renovations that were larger in cost did not appear on the list of minor renovations, but rather appeared on lists of capital projects being prepared for revision of the five-year capital plan. At times, more costly renovations were brought forward as a single item. For example, the President forwarded a request for lab renovations in the Research Centre directly to the Finance Committee, a request that surprised a senior physician as it had not been discussed in senior meetings. Both the Emergency renovations and laboratory renovations ended up on the list of projects approved for 1992-93 expenditure.

8.3.3 Major Equipment Acquisition

The five-year plan did contain items for major new or replacement technology, but these items seemed to constitute proposals rather than final decisions, as specific spending proposals, with a detailed workup and justification, would be
required when the equipment was scheduled for purchase. Therefore, decisions about major technology seemed to be made in a manner that was consistent with Meyer's (1984) description of a "pliant utility model". At Riverview, proposals such as ones for MRI technology and a lithotriptor were "cycling", awaiting need justification, fiscal and technical evaluation, or financing, before the final decisions were made on expenditures. When there was discussion at Riverview about these acquisitions, it did not focus on the effectiveness of the technology, the need for such technology in the region or alternate uses of capital funds. Sponsors or champions seemed to be an important factor in moving a raw proposal towards a refined one. In the case of the lithotripter, a Board member seemed interested in acquisition of this equipment, some funds had already been donated for this purpose and the President was investigating the possibility of a joint proposal for this equipment with another hospital. In the case of MRI technology, the President had told physicians, who were interested in acquiring the technology, that they had to "find a hook" in developing a proposal in order to gain Ministry approval. Formal analyses of need or costs occurred following inclusion of the item in the five-year plan and these items seemed to represent strategic decisions, believed to solidify Riverview's position as a "leading edge" hospital.

A number of studies support the contention that the acquisition of major new equipment and programs relate to such strategic considerations, especially in teaching hospitals (Greer,
Although a number of authors argue for more rigorous evaluation of new technology and consideration of the population needs in adoption of new technology (Deber et al., 1994; Kamath & Elmer, 1989), others acknowledge that the mission and goals of the hospital are legitimate considerations in technology acquisition (Laupacis et al., 1992) and that beliefs and values are part of policy-making about technology adoption (Battista, 1992). The study of Riverview suggests that strategic decisions precede formal analyses and reflect in part, the views of key decision-makers about the mission of the hospital, beliefs and values about research, leadership and "state of the art" care, and the desires of physicians for equipment that enhances their practice.

8.3.4 Capital Projects

Capital projects, a major component of the capital budget, involved investment in buildings, land or major renovations. These items were similar to major new technology in that they had been identified as raw proposals in the five-year capital plan and they had senior sponsors within the organization. Some of the capital projects were identified as priorities and these ones received the most attention during field work, while others in the five-year plan were in progress or on the "back burner" with no resources dedicated to them.

Decisions about the CIU, the OR and the Research Centre expansion projects, were justified, at the time of approval, on a strategic basis. Although this decision occurred prior to the
study period, reports and conversations indicated that the decision was linked to the abandoned strategic plan developed by a small group. As with major technology acquisition, formal analyses occurred following the strategic decision, a sequence that is consistent with Mintzberg's (1994) distinction between strategy-making and strategic planning. The decision sequence however, is in reverse order to that described in Bower's (1970) process model of investment decisions. In his model, projects began with a definition stage in which technical and economic analyses were initiated; the impetus stage was second and involved the willingness of a sponsor to support a project. At Riverview, it seemed as if the impetus phase came before analysis and this may constitute one difference between a hospital and a business firm.

Bottom-line cost estimates had been provided for both major priority projects, estimates that were revised upwards several times in subsequent years. The OR planning involved the use of consultants who engaged in detailed analyses, but this ongoing work was not discussed at the Board level, but rather between the President and an OR Planning Committee. There was no discussion of detailed planning for the expansion of the Research Centre by any senior groups during the study period. Often, such capital development is tied to the so-called "dowries" used by teaching hospitals to attract high-profile and specialized physicians (Young & Saltman, 1985). At Riverview, the recruitment fund provided such dowries to attract new physician Division and Department Chiefs. Although not openly discussed, there was some indication that the
OR project was tied to the recruitment of the Chief of Surgery. The OR project had been justified on the basis of one of the four foci that called for the Chief's particular surgical skills and these skills could best be utilized with larger and up-to-date operating rooms that were part of the plans for the new OR project. It seems likely that the Chief was attracted to Riverview, in large part, because of the hospital's plans to embark on a program and project that was consistent with his skills.

Capital spending on major projects was less amenable to bureaucratic procedures and predictable expenditures within a fiscal year. Although a capital project may have been approved by the Board in the past, external factors, such as MOH approvals, the decision of a City Committee or the availability of land, often dictated when the President forwarded spending proposals to the Finance Committee. The ad hoc timing of requests and the seeming absence of procedures for preparing an annual update to the five-year capital plan made it difficult for Board members to know the state of the capital budget when they were making decisions on a capital item. Despite this lack of information, Board members did give approval to smaller capital projects, such as the heliport and the CIU. The written and verbal justifications for these projects were strategic ones, and information on operating costs or anticipated benefits were minimal for the heliport and non-existent for the CIU. Although the Finance Committee began asking for a review of the capital priorities in the Fall, it was not until they halted spending that they obtained a review of priorities and a
comprehensive plan for the next fiscal year, as well as an outline of potential spending for the next five years.

At Riverview, sponsors for capital projects and items were evident, such as those described by Bower (1970) in his study of a national business firm and Meyer (1984), in his study of capital budgeting in hospitals. The President seemed to sponsor the Research Centre, as did the deputy director of that Centre, while the Chief of the Department of Surgery sponsored the OR Project. Planning for expansion of the Research Centre was never discussed during the study period, although the final comprehensive plan showed that considerable sums had been spent on planning. In contrast, OR planning was discussed frequently at senior meetings and the OR planning group had to revise the project downwards on two occasions. By the end of the study period, the costs of the OR project were estimated to be less than the amount originally approved by the Board while those of the Research Centre were unchanged. As it was clear that capital projects would be delayed, there was conflict about the order in which projects would proceed.

8.4 Power and Capital Allocations

Pfeffer (1977) notes that the use of power tends to be unobtrusive and that secrecy, the use of committees, the control of information and the promotion of favoured criteria are employed to legitimize decisions and make them appear "objective". The President tended to be secretive about some items for which he sought Board approval; he encountered difficulties with respect to information on the number of helicopter flights and consultation
with regard to parking proposals. In some cases, he was vague and seemed to control information about items such as, communications with the Ministry about the OR Project, the operating implications of capital expansion of the Research Centre and the background to the renovations for the Clinical Centre. The EVP seemed to promote favoured criteria for the selection of capital items for the 1992-93 when he proposed criteria, almost all of which would favour maintenance and renovation. However, these criteria seemed to have more symbolic than instrumental uses; although maintenance projects were included on the final list, so were the CIU, heliport and renovations to the Research Centre. The list seemed to constitute a compromise between items that promoted strategic directions and those that supported current operations.

The use of politics, in Mintzberg's (1983) sense of the term of illegitimate behaviour not formally sanctioned by the organization, was also evident. The President attempted via his business plan, albeit unsuccessfully, to secure spending decisions on capital project priorities before strategic planning was completed. When it seemed that the President might shepherd his business plan through the Board approval process, senior physicians called for a meeting with Board members. As a result, the President was forced to abandon his business plan and the Board reconfirmed its earlier decision that the OR project was a priority for construction and should proceed before the Research Centre expansion.

Once the President was forced to focus on strategic planning
and abandoned his attempt to set priorities in a business plan, he brought senior managers together with selected senior physicians to develop a new capital plan with a re-examination of priorities for spending. He began by having the Director of Planning present a series of options for the OR project, options that ranged widely. As they compiled all the current requests, past proposals, projects in progress and approved projects, the need to make choices was startlingly evident to those around the table. At this point, the decision-making process was similar to that suggested in the dual model, however neither the senior administrative group or the senior physician group were unified with respect to their views on priorities. Negotiation and compromise was reached with the development of an agreement on continued planning funds for the OR Project and recognition of this as a priority, some maintenance and renovation projects and some smaller projects with a strategic dimension. The major change in the five-year plan was delay of major projects, a commitment to only one year's spending and a reserve fund.

The process of deciding on a capital budget was characterized by more conflict and delay than the process of deciding on the operating budget. The use of power by all senior groups was evident. The formal power of the physician group to be consulted and of the Board to grant approval with respect to capital spending was used by both of these groups to block and delay capital spending until their concerns were addressed. On several occasions, the President used his formal power to formulate capital
proposals and to bring forward items to Board members for approval, such as the heliport or the parking project proposal. The Senior Management Team used its influence with the President and other senior groups in arguing for maintenance and renovation projects in the short-term, delay of spending on major capital projects and conservative approaches to capital financing. They assisted the President in using their influence with others; the EVP negotiated a large reduction in the size of the OR project with the OR planning group and generated a proposal that broke the deadlock in decision-making about the annual capital budget.

8.5 Responding to Fiscal Stress

Most of the literature that addresses resource allocation and fiscal stress focuses on how the process of allocating the operating budget changes, with little discussion of the capital budget. During the period of field work, sources of funding for capital projects began to dry up. A growing operating deficit threatened to reduce the amount of funds that could be used for capital purposes, a capital grant for the OR Project seemed increasingly unlikely and senior managers advised against using the borrowing authority to finance capital projects.

In response to these threats to capital financing, the Senior Management Team attended to the problems of balancing the operating budget, reduced operating expenses, increased non-MOH revenue and paid off the outstanding loan. However, there were limits to the degree to which they would quickly reduce operating costs to finance capital expansion and they were alarmed about the operating
costs that might result from such expansion. During the early field study period, the President persuaded the OR Planning Committee to look at lower cost alternatives and reduced the size of the project somewhat to ensure the borrowing limit would not be exceeded. It was not clear to what extent the President pursued a capital grant for the project, but at one point, he told senior groups that the grant was unlikely as the provincial government was in a reduction mode. When he was no longer able to borrow funds and the grant seemed doubtful, the President proposed that the OR Project be further reduced.

At Riverview, fiscal stress contributed to a number of decisions about the capital budget: the delay of major, planned capital projects, the scaling down of a major project, and the development of more formal and more conservative policies with respect to capital financing and decision-making. The policy decisions with respect to capital budgeting were more conservative in that there would be no borrowing to finance the capital plan, at least for 1992-93, only part of the allotted funds would be spent and there would be reserve funds every year.

As with operating budget decision-making, choices were required in the final stages, but in the case of the capital budget, decision-makers seemed even more overwhelmed by the choices required and somewhat at a loss to choose between such potential uses of funds as air-conditioning of existing patient units and investment in the OR project. The list of potential uses of capital funds reflected expectations at Riverview, expectations
that could no longer be met. It was the EVP who negotiated the reduction in expectations for the OR project and proposed an approach to the annual capital budget based on the use of criteria. These criteria seemed to consist of acceptable justifications or considerations in choosing an item for expenditure, such as patient safety, quality of care or cost impact, but it was not clear how they would be applied to set priorities for spending. However, the adoption of a list of criteria did seem to break the deadlock in decision-making and "rationalize" the approach for senior groups. To a great extent, the criteria seemed to serve symbolic purposes, rather than providing an explicit basis for decision-making.

8.5 Summary

In sum, themes identified in the analysis of events at Riverview with respect to allocating the capital budget were the conflicting goals and roles of senior groups, the diverse processes for deciding on components of the capital budget, uses of power in capital allocation and responses to fiscal stress. The formal roles of individuals and groups helped to explain the goal preferences with respect to capital budgeting, and highlighted the relationship between operating and capital budgets.

In the past, the President seemed to have been able to pursue capital redevelopment and manage such projects with just the input of the former VP Finance. However, reduced funding and Board and physician distrust changed this traditional arrangement. The relationship between the President and the Board and senior physicians deteriorated over the study period, mostly in relation
to capital projects, and conflict forced an opening up of the capital planning process. Vice Presidents and senior physicians became more involved in the major projects component of capital budgeting.

Decision processes varied depending on the component of the budget. Capital equipment decisions, at least for relatively low cost items and replacement equipment, were the most "bureaucratized" and the least contentious. Replacement of fairly major medical equipment underwent the most extensive financial and technical analysis prior to a spending decision, and for these, the need was justified in terms of existing hospital data. Major new technology was proposed on the basis of strategic reasons related to the mission of excellence, financial and need analyses followed, with proposals "cycling" until they were refined into concrete spending proposals. Major capital projects were also approved on the basis of strategic reasons and bottom-line costs, but the longer time period required for the subsequent detailed planning and analyses made these proposals vulnerable to changes in the economic and political environment.

Political processes were most evident with respect to major and priority capital projects and became more intense as the prospect of adequate funding to meet organizational expectations receded. Decision-makers, who seemed overwhelmed by the choices they faced, attempted to rationalize decisions by criteria setting and proposing delays until strategic decisions and other information was available. To a great extent however, the criteria
served symbolic purposes rather than rational ones and decisions reflected a compromise between strategic positioning and operating concerns. Political factors did lead to an opening of the capital plan to wider scrutiny and input and established the precedent of a comprehensive annual capital plan with detailed information. New policies were also established that provided a framework within which capital funds would be allocated, such as a reserve fund, a high technology fund and no borrowing.
CHAPTER 9

CONCLUSIONS

In this chapter, I summarize the major themes in resource allocation at Riverview in terms of the initial research questions. I also discuss the contribution and limitations of the study as well as some implications of the findings for decision-makers, for further research and for public policy are discussed.

9.1 Summary and Conclusions

The study began with broad research questions about resource allocation decision-making in hospitals:

1. Who are the key actors in resource allocation decisions and what roles do they play?

All three senior groups participated in and influenced resource allocation decision-making. The senior administrator group was responsible for guiding the decision-making processes and this group's central position, formal authority and co-ordinating role enabled senior administrators to be very influential with respect to allocation decisions, particularly marginal changes in allocations. Most of the changes in the operating budget allocations were marginal ones, but even the more substantial changes in the allocation of capital funds and changes in the capital plan were influenced by senior administrators. A number of factors seem to contribute to this influence. Senior administrators had, and were perceived to have, intimate knowledge and understanding of the organization. They also received a great deal of information, both internal and external, formal and
informal, and they received it earlier than most other groups.

Senior physicians increased their involvement in resource allocation decisions during the study period and they influenced marginal changes in allocations to clinical services. Because of their diverse interests, they sometimes had difficulty coming to a within-group consensus, as for both operating and capital decisions, clinical divisions sometimes had to compete for funds. Because some members of the senior physician group participated in administrative meetings and Board meetings, there were a number of points at which they could intervene to influence decisions. As physicians held the right of approval, they were able to block or delay decisions until their concerns were addressed, an action they took with respect to the capital budget. In an exceptional case, a powerful physician representing a subunit was able to bypass the senior group altogether and deal directly with key senior administrators and board members.

The Board of Trustees also held the right of approval, but its influence on operating decisions was most evident in the parameters set for budgeting, rather than specific decisions. Thus the Board's influence was exerted most often through informal communications with the President and at Board Committee meetings that informed administrators of Board concerns and goal preferences. The Board exerted more influence with respect to major capital decisions and members exercised their power to delay decisions and block spending until their concerns and priorities were addressed.
The process of decision-making was facilitated or hampered by the quality of relationships between any two groups. Although the normal pattern of interaction was between administrators and physicians and between administrators and board members, this changed when capital allocation was stalled, in large part because of deteriorating relationships between the President and the other two groups. In that situation, senior physicians approached the Board directly to voice their concerns and this approach was effective with respect to their concerns about the process of decision-making.

The formal roles of senior decision-makers and their perceptions of these roles strongly influenced their goal preferences in resource allocation decision-making. Although all groups supported the goals of financial stability, maintenance of services to the community, capital redevelopment and strategic change, when choices were required, the preferences of individuals and groups were evident. The role of senior administrators, notably the Senior Management Team, enabled this group to influence overall resource allocation decision-making in a direction that favoured goals that promoted organizational stability. The Senior Management Team was able to create reserves and funds for special purposes at a time when they knew that slack funds were available. These funds were used for paying off the loan, providing for employees who required retraining or whose jobs were eliminated, and for averting conflict between Riverview and the Clinical Centre—all measures that avoided disruptions and promoted
stability within the organization.

2. What kinds of resource allocation decisions are made and does decision-making vary by the type of decision? What kinds of problems are encountered during decision-making?

Two processes of resource allocation decision-making were examined, one for allocation of the operating budget and one for allocation of the capital budget. Although these processes were kept separate, decisions for one budget affected the other. While there was discussion of how the cash flow from the operating budget provided capital funds, there was little discussion of the operating budget implications of capital decisions.

Overall, the process for deciding on operating allocations was more orderly and less fraught with conflict than the process for deciding on the capital budget. In the process for the operating budget, time frames for decisions were set, parameters and guiding principles were identified at the beginning of the process, and there were established and known procedures for formulating a proposal. The processes for decision-making about the capital budget as a whole, was more ambiguous and disjointed, and historically, the President seemed to have operated on the basis of a five-year plan, rather than an annually reviewed budget for the fiscal year.

In addition to the broad categories of operating and capital allocation decisions, there were sub-categories within each budget that were distinguishable in terms of decision processes. Decision processes related to the operating budget could be distinguished in
terms of those for the base budget and those for marginal changes. For the capital budget, sub-categories of decisions were those for capital equipment, renovations, major new technology and major capital projects.

The major problem in resource allocation decision-making was the problem of choice when declining revenue increases meant that not all expectations could be met and existing services could not be provided in the same way or at the same level as in previous years. Compounding the difficulty of choice was uncertainty about funding levels, lack of data and information to assess the consequences of choices and conflicting goals. As cuts were made, issues of fairness about the distribution of burdens of decisions were raised, sometimes with regard to different patient populations, sometimes with regard to different levels of staff.

3. How are decisions made and what procedures are used? Are there identifiable stages in decision-making? What kinds of information are used and how are problems resolved?

The process of allocating the operating budget was a relatively orderly one, and distinct phases were evident in which administrators framed the process, with consideration given to the goal preferences of other senior decision-makers, built the proposal and sold the budget to the senior physicians and Board members.

The early phases of budgeting were characterized by hierarchical authority and bureaucratic procedures. In framing the budget, senior managers decided to use a base budgeting approach
and directed departments to make across-the-board cuts. The major proportion of the operating budget was allocated on this incremental basis. As the budget was built and marginal changes in allocations considered, the process of decision-making shifted to one suggested by a dual authority or coalitional bargaining model. Some marginal changes were proposed on the basis of formal analyses, but most often changes were based on professional judgement, soft information and negotiations. Power and politics also played a role in marginal changes in allocations, and this was most evident in the political activity of one subunit that was perceived as prestigious and able to attract scarce resources to the hospital. Despite across-the-board cuts and the Board's usual insistence on "following process," this decision was one made by the Board following approval of the budget, a decision that was consistent with triad and political models of hospital decision-making.

The distinction between base and marginal allocations did not apply to the capital budget. Instead, decision processes for this budget seemed to vary by component and ranged from a relatively orderly and bureaucratic procedure for decisions on the capital equipment budget, for which there was a consensus on decision rules, to a rather conflict-ridden, political process for major capital projects, with trade-offs, end runs and bargaining sessions. Replacement or enhancement of relatively costly equipment was subject to financial and technical analysis for the decision on which brand to purchase, but new high technology was
added to the capital plan on the basis of a strategic decision. Similarly, large scale construction projects were originally added to the capital plan for strategic reasons, and justifications emphasized "excellence" in patient care, teaching and research as well as a "competitive edge" position for Riverview. Strategic capital proposals had sponsors, but they were not based on formal analysis of need, cost or technical criteria. Instead, strategic items cycled (Meyer, 1985), undergoing analyses or the detailed planning required to refine proposals prior to spending decisions.

Not only was there no established procedure for reviewing and formulating a capital budget annually, but also, major capital projects and new technology were subject to external factors that constrained decisions and affected the speed with which decisions could be implemented. Therefore, these components were more vulnerable to being sidelined by changes in economics, changes in the political environment and changes in the membership of senior groups. The OR Project, despite Board support, was threatened by declining capital funds and by the President's preference for the Research Centre project. The strategic focus that had been used to justify the project had been abandoned by the time of the study period and the justification then hinged on safety problems, problems that could be addressed with a lower cost project.

The kinds of information used for decision-making about the operating budget included hard data about services and bed utilization, but for the most part, decisions were based on the judgement of the Senior Management Team, knowledge of the
organization and the hospital network and comparisons with other hospitals. The Team knew that Riverview's information systems were inadequate for cost analysis purposes and decisions about the cost consequences of decisions often depended on professional judgement. Information used in capital budgeting varied by component. The most detailed analyses were conducted for relatively low cost equipment replacement decisions, while strategic decisions involving high costs were taken using minimal formal analysis. Once the decision was taken however, analyses were undertaken to justify need and estimate costs. Overall, resource allocation decision-making at Riverview was fairly closed in that most employees, most of the medical staff and the public had little input into strategic or resource allocation decisions. Considerations about the public or community related to changes in existing services, on the assumption that those services already offered were the needed ones, and some data on these were available and used.

4. What reasons are given for resource allocation decisions. What goals, values, arguments and principles are put forward on behalf of courses of action?

The reasons given for resource allocation decisions varied, but overall, decisions about operating allocations were justified in terms of the goals of fiscal viability for budget cuts and maintenance of service levels for avoiding cuts. Within the context of making operating budget decisions, arguments for the elimination of positions, reduction of hospital beds and
introduction of a preadmission unit focused on efficiency. Arguments that justified decisions not to cut further or even to increase an allocation were those of fairness and avoidance of disruption within the organization.

With respect to the capital budget, the goals most often cited to justify spending decisions were those of strategic change and capital redevelopment. However, the goals of maintenance of service and fiscal viability were also cited to justify decisions to delay spending, to adopt more conservative policies and to scale down the size of a project. Within the context of making capital budget decisions, arguments for projects such as the CIU and heliport, were supported for strategic reasons and the belief that these decisions would give Riverview a "competitive edge," promote "excellence" in care, and better fit with the stated mission of being a leading academic health sciences centre. Although the OR project had initially been approved on the basis of strategic reasons as well as safety concerns, the strategic plan was changing in a way that made this project seem more vulnerable to reduction, forcing proponents to more often defend the project in terms of safety reasons and the disruption to operations in merely renovating the current site.

Overall, Riverview's resource allocation decisions, both for the operating budget and the capital budget, leaned more towards promoting stability than to introducing strategic change. The change in operating and capital budgets from that of previous years and changes in fiscal policies seemed to constitute an initial
response to fiscal stress. If the original capital plan was any indication, fiscal stress was relatively new to Riverview and this major external factor led to changes in the organization's expectations, policies and procedures to address the new economic constraints. There were indications that decision-makers wanted to find a more "rational" basis for decision-making, but were hampered by an absence of established criteria and lack of data and information on which to base decisions. As a result, there was heavy reliance on professional judgement and informal comparisons with other hospitals as well as an attempt to establish criteria for various decisions. These criteria however, were sometimes subject to manipulation and to symbolic, rather than actual use.

Changes in the external environment, such as reduced funding increases and changes in the internal environment, such as changes in the administrative structure and membership in groups, all contributed to resource allocation decisions. These changes began to raise new questions within the organization, questions about trade-offs between current services and future programs, the degree of financial risk the organization should assume, the role of physicians in management of resources, and the relative share of resources that ought to be allocated to services, research and teaching. Questions were generally not raised however, about public values or other ethical aspects of resource allocation decision-making, how to assess the relative need for services or new programs within the region, or how to evaluate existing programs. On the whole, the focus was on addressing internal
concerns, with little attention given to external ones.

The findings of this study highlighted the considerable complexity of decision-making in a hospital. Decision-making not only generated changes in allocations, but also changes in policies, operating procedures and relationships among senior groups. In turn, these policies, procedures and relationships affected subsequent resource allocation decisions. The time and energy devoted to budgeting was considerable, yet all senior groups had to address other issues and ensure that the hospital was providing services on a daily basis and operating efficiently. Despite the attention required to address allocation decisions, senior groups had to deal with death threats from disturbed employees, disgruntled and angry neighbours, changes in Board membership for political reasons, medical staff anxiety about regional rationalization, contract negotiations with radiology physicians, law suits and inquest hearings, and a host of other issues that arose regularly in the daily life of the organization.

9.2 Contributions and Limitations of the Study

This study contributes to an understanding of Canadian hospitals by providing an in depth description of a phenomenon rarely studied by ethnographic methods, that of resource allocation decision-making. Unlike static models of decision-making, such a description underscores the dynamic nature of resource allocation decision-making and highlights the interactive and changing aspects of the process. Thus, beyond knowing that physicians "participate" or have "input" into decisions, this study explores the way in
which they exercise their influence.

Although the findings of this study cannot be generalized to other hospitals, the study does provide a basis for comparison of findings with those reported in other studies of hospitals and with theories of organizational decision-making. For example, the findings of this study support a triad model of hospital decision-making, but do not support the proposition that physicians will consistently dominate resource allocation decision-making.

This study is limited in several respects. First, the focus was limited to one hospital, over a relatively short time period in the life of an organization. A longer time frame and the study of more hospitals would strengthen the understanding of hospital decision-making, making it more likely that one could sort out the effect of internal and external changes on decisions and the enduring and changing aspects of decision-making. The focus on internal decision-making in one hospital meant that external factors affecting resource allocation were not explored in any depth and therefore, the focus of the study might overstate the case for internal factors in decisions.

Data collection and analysis may have been influenced by several factors. As I have a nursing background and previous experience in hospitals as a nurse, I may have been influenced by this experience in what I attended to while observing and listening to others. As I spent much of my time in meetings attended more often by senior administrators than any other group, my observations and conclusions may have been influenced by this
closer involvement with one of the three groups. In addition, much of these data were collected at formal meetings, yet it was obvious that many side meetings, telephone conversations and informal discussions took place between two or more individuals, exchanges that I learned about by chance and second hand, rather than directly.

9.3 Implications of the Study

This study focused on one hospital, but it is likely that many of the issues in and processes of resource allocation are similar to those found at other teaching hospitals. Implications of the study include those for hospitals, those for further research and those for public policy.

9.3.1 Implications for Hospital Decision-makers

Although this study was carried out to explore and describe resource allocation decision-making rather than to generate prescriptions for such a process, some implications for teaching hospitals can be identified based on the study of Riverview.

The Chief Executive Officer has an important role in balancing the demands of the current operations while guiding the hospital towards a preferred future. When responsibility for much of the internal operations of the hospital is delegated to another position, there is a danger that the loss of intimate contact with the details of operations and other key decision-makers will affect the CEO's ability to lead the hospital through change. While the CEO may be astute in identifying directions, he or she must also be perceived as knowledgeable about the organization and attentive to
the concerns of other decision-makers. When responsibilities for managing internal operations are delegated, extra efforts are required to ensure that overall responsibility for hospital operations is retained. Mechanisms of communication between the CEO and senior managers must be in place to ensure that the CEO is well briefed on internal operations and that communication with key decision-makers in other senior groups is maintained. Such knowledge seems essential in influencing resource allocation decisions, and if that power accrues only to the position with a mandate for current operations, it seems likely that decisions might be unduly biased towards maintenance of what exists, rather than strategic change.

Hospitals ought to give consideration to the amount and quality of internal and external information that would assist in decision-making. Fiscal stress raises questions about how overall resources ought to be allocated to various purposes. For example, what percentage of a teaching hospital's operating budget should be allocated to patient care, teaching and research? What percentage of the budget should be devoted to replacement of existing equipment or maintenance projects? Although information systems cannot answer ought questions, they should be designed to answer is questions and provide data on current allocations from the perspectives useful to decision-makers.

Hospital management operates on a considerable amount of soft information and rumours that circulate in the hospital network. Official information from the Ministry of Health often arrives long
after resource allocation planning must take place. Senior administrators and their hospitals benefit from the advance warnings, ideas and trends provided by the informal network and contacts within this network should be fostered. Although an increase in the amount and quality of hard information on costs and service delivery is needed to predict the impact of alternatives and to make choices, soft information is also valuable in decision-making.

Decision-makers should take care that strategic decisions are not totally driven by the internal organization, without careful consideration of the needs of the local and regional community. Although teaching hospitals must consider internal values and goals, beliefs about the hospital mission and other aspects of the internal organization, they must be open to the perspective of outside individuals and groups, particularly with respect to strategic change. Strategic choices should be explored and justified on the basis of need in the external environment. Commitment to a spending decision should follow a meaningful level of economic analyses and technical analyses as well as consideration of other uses of capital funds.

The conflict inherent in resource allocation decision-making increases as resources become more scarce. One source of conflict is the perceived legitimacy of decisions and hospitals can enhance the legitimacy of decisions by giving consideration to procedures and processes used in decision-making. Such procedures can improve resource allocation decisions and prevent or reduce the level of
conflict. As conflict delays decision-making and consumes the time and energy of decision-makers, hospitals should attend to such mechanisms. Capital equipment committees with broad representation, formal analyses, the provision of data and information on options and the development of a consensus on criteria for various decisions are ways in which legitimacy of resource allocation decisions can be increased and conflict reduced.

Middle managers and staff specialists provide senior administrators and physicians with information and analyses on operations and capital projects and serve as an important link between senior groups and the providers of services. These positions seem most vulnerable in organizations that must engage in downsizing and care should be taken in such exercises that the quality of decision-making at the senior level is not decreased with the elimination of these positions. As middle managers often have a grasp of the impact of alternatives on operations, senior managers depend on their advice.

Senior administrators are the first to know if extra funds are available at the end of a fiscal year and at the end of the budgeting process. As there is a short time frame in which to make decisions about additional or unexpected funds, there is apt to be little discussion or examination of hospital priorities and senior administrators are in a favoured position to recommend how such funds should be used. The possibility of surplus could be anticipated, given the surplus creation behaviour of senior
administrators, and priorities for the use of surpluses could be established ahead of time by a more broadly-based group.

9.3.2 Implications for Further Research

A number of questions arising from the study merit further research. One question is the nature of relationships among administrative structure, resource allocation patterns and conflicts in decision-making. As Riverview's structure and budget were along functional division lines, conflict was often between functional departments and divisions and comparisons were made between patient care and non-patient care areas. Does a hospital structured along clinical program lines make different kinds of resource allocation decisions? Does the pattern of conflict shift to ones reflecting the administrative structure?

Further exploration of the creation of special purpose funds is warranted. Who influences the creation of such funds? Under what circumstances will funds be established and for what kinds of purposes? Over time, do such funds limit budget flexibility? How do such funds affect resource allocation decisions in the short and long term?

As middle managers and staff specialists seemed to provide some of the data and formal analyses used in resource allocation decision-making, downsizing in hospitals may have an effect on the extent to which hard data are used in decision-making. What is the effect of the loss of hospital middle management positions and staff positions on formal analyses for resource allocation decision purposes?
At Riverview, a strategic plan was not in effect at the time of resource allocation decision-making, although at times, decisions were characterized as consistent with strategic directions. To what extent does a hospital's formal strategic plan steer resource allocation decision-making? Are shifts in funding evident over time, following adoption of a strategic plan?

Riverview seemed to be in the early stages of fiscal stress. What is the pattern of responses to fiscal stress over time? Do hospitals change the basis of allocation or the reasons for allocation decisions when the degree of fiscal stress changes?

9.3.3 Implications For Public Policy

Governments should give attention to three areas of public policy with respect to hospitals. First, attention should be given to the ways in which public policy would stimulate greater public consultation by hospitals on services, strategic directions and strategic change. Second, governments should consider the implications of the shift of research infrastructure from its traditional base in universities to hospitals. The growing shift has an impact on operating and capital budgets and it seems that little consideration has been given to the implications of this trend. Third, governments should examine their policies and guidelines on capital expenditures and projects to ensure that there is adequate assessment of need and local and regional consultation.
9.4 Concluding Comment

What a hospital does in society depends on where it spends and invests its resources. The process of making decisions about how resources will be spent within a large hospital involves many actors, perspectives, interests, and goals. This examination of resource allocation decision-making underscored the complexity of a large teaching hospital and the multiplicity of factors that influence decisions. When I asked a senior administrator if his work was becoming more complex each year, he agreed, telling me that when he began his career in hospital administration, the major challenge facing administrators was "how to get hot toast up to the patient floors". While many patients might argue that this earlier challenge has never been successfully met, hospital decision-makers must address resource allocation challenges that seem no more amenable to easy answers.
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technology assessment into the capital budgeting process. 


Appendix A
HOSPITAL RESOURCE ALLOCATION DECISION MAKING:

SUMMARY OF A PROPOSED STUDY

The Topic

The purpose of this study is to explore the process of resource allocation decision making in hospitals. There are several reasons why hospital resource allocation decision making merits study. First, the necessity of making choices about resource allocation has increased due to the simultaneous demands for budget constraint by government and for resource expenditure by professionals and the public. In recent years, provincial governments have been viewing the growing percentage of the provincial budget devoted to health care with alarm and have attempted to limit spending in the hospital sector. There has been increased pressure on hospitals to make choices among competing demands for new or additional technology, services and programs. Second, there is greater debate about how health care resources should be spent. Hospitals deal with multiple stakeholder groups, each with a different perspective on how resources should be allocated. Third, there is some evidence that Canadian health executives experience problems in resource allocation decision making, yet little is known about how such problems are resolved (Chown, 1990).

The focus of this study is macroallocation of hospital resources, the processes involved in making macroallocation decisions and the problems involved in the process, by they organizational, political, ethical or procedural. Major assumptions underlying this study are that macroallocation is a complex process and that decisions must be made under conditions of uncertainty. An extensive review of the literature shows that while there is a considerable amount of discussion about how resource allocation decisions ought to be made, there has been little empirical research that examines what, in context, is involved in actually making these decisions.

The Method

The proposed research is aimed at examining the process of decision making in all its complexity, rather than isolating a few factors from the context in which decisions must be made. Given the lack of earlier research in this area and the absence of theory, the proposed study will be an exploratory one to describe the factors involved in decision making and to generate concepts and hypotheses rather than testing ones that have been developed.

An exploratory study calls for a qualitative approach rather than a quantitative one, and there is a strong scientific tradition in qualitative methodology in organizational research. The methods involve document analysis, observation, and interviews with
informed individuals. In the proposed study, a case study design will be used and the focus will be on the macro level of decision making in a hospital. Hospital documents such as mission statement, strategic plan, financial and other reports relevant to resource allocation will be examined. Attendance at board and committee meetings that address resource allocation issues will provide data on the process of and considerations in decision making. In addition, unstructured interviews and discussions with individuals who are informed about and involved in decision making will be sought. Informants include senior levels of management, members of the board of trustees and senior medical personnel. All aspects of the decision making process are of interest, including procedures, guidelines or rules, constraints and opportunities as well as the financial, organizational, political and ethical considerations.

The intent in this research is to understand how resource allocation decisions are made and key aspects of such decision making. The focus is on the process rather than individuals of the hospital per se. Consideration has been given to the confidential aspects of the study. The name of the hospital and of individuals participating in the study will not be identified in any written material and pseudonyms or codes will be used to protect anonymity. Raw data collected during the study will be kept confidential and stored in locked cabinets. A final report will be available to those participating in the study.

The Researcher

I am a Ph.D. Candidate in the Department of Health Administration, University of Toronto and the proposed study is my doctoral dissertation research. The research will be supervised by a committee chaired by Dr. Peggy Leatt. I have a background in nursing and in the past, have worked in hospitals as a staff nurse and teacher. My most recent full time work experience has been as a senior administrator and health policy analyst for a professional association and over the past few years as a student, I have engaged in contract work in the health care field as a writer, consultant and statistical data analyst.

Marianne Lamb
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Board of Trustees Minutes, June 24, 1992
Comments on Code of Conduct, no date
CONSENT FORM

RESOURCE ALLOCATION DECISION MAKING IN HOSPITALS: AN EXPLORATORY STUDY

This research is being conducted by Marianne Lamb, Ph.D. Candidate, Department of Health Administration, University of Toronto, as a doctoral dissertation. The thesis supervisor is Dr. Peggy Leatt, Chair, Department of Health Administration (416-978-2736). The purpose of the research is to understand the process of resource allocation decision making in hospitals and the attendant problems in such a process, be they organizational, ethical, political, procedural or practical. As few studies of this topic have been undertaken in the past, all aspects of resource allocation decision making will be of initial interest, although the focus will narrow as the study proceeds.

The intent of the research is to understand how resource allocation decisions are made and key aspects of such decision making. The intent is not to evaluate the decisions made nor to evaluate the work of individuals in the hospital. The names of the hospital and individuals participating in the study will not be identified in any written results and pseudonyms or codes will be used to protect anonymity. Raw data collected during the study will be kept confidential and stored in locked cabinets. A written report of the findings will be made available to those participating in the research at the completion of the study.

As you are knowledgeable about the resource allocation process in hospitals, your participation in this study would be greatly appreciated. Participation would involve an initial interview of approximately one hour, with the possibility of one or more follow-up interviews of similar length during the estimated nine-month period of data collection. The interview will be similar to a discussion and to facilitate data collection, I would appreciate your consent to make a tape recording of the interview. Tape recordings and transcripts will be destroyed at the completion of the study. You are free to decline to answer particular questions, to decline tape recording or to discontinue the interview at any time. If you are willing to participate in this research, please sign this form.

Marianne Lamb
Investigator
Appendix D
INTERVIEW GUIDE

1. How long have you been in your current position at Riverview? What did you do prior to that?

2. I am interested in your view of resource allocation decision-making at Riverview. How do you see your role?

3. What is the process of resource allocation decision-making at Riverview?

4. Are there principles, guidelines or assumptions that guide resource allocation decision-making at Riverview?
IMAGE EVALUATION TEST TARGET (QA-3)

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