

LEARNING FROM HISTORY: PROGRAM REVIEWS AND PUBLIC SAFETY

Daniel Cohn, Lorne Foster and Ian Greene

Canada appears headed for a new round of 1990-style program reviews aimed at producing spending restraint. This article uses evidence from two provincial inquiries into failures of government to caution that conducting such reviews on a whole-of-government basis creates too large a task to undertake without endangering the lives of Canadians. The danger involved is magnified further when the task is done in an atmosphere of crisis. In order to effect sound public management, program reviews should be done not on a whole-of-government basis but at known periodic intervals in individual ministries or program areas.

En une sorte de retour aux années 1990, le Canada semble se diriger vers un nouveau cycle de révision des programmes gouvernementaux afin de comprimer ses dépenses. Mais à l'examen de deux enquêtes provinciales sur les défaillances du gouvernement, les auteurs montrent qu'une révision d'envergure qui touche l'ensemble des programmes mettrait en danger la vie de nombreux Canadiens, un risque d'autant plus grand si la tâche est menée dans un climat de crise. Pour maintenir une saine gestion publique, préviennent-ils, les révisions de programmes doivent s'effectuer à des intervalles réguliers et établis d'avance, et dans quelques ministères désignés ou pour des programmes spécifiques.

Ministers and their senior bureaucrats should not set out to endanger the lives of their citizens. Nevertheless, across Canada in provincial capitals and in Ottawa, our top public servants and ministers are setting staffs to work, or soon will be, on top-to-bottom and side-to-side redesigns of government that history has shown are too big to undertake without endangering the lives of Canadians. The danger involved is only magnified when such redesigns are done in an attempt to save money, by reducing the role of the state in our daily lives during an atmosphere of crisis.

These exercises are described by a variety of names including strategic reviews, expenditure reviews and core-service reviews. We will call them whole-of-government program reviews. The goal is to make sure that the activities of the state advance the priorities of our elected governments in the most cost-effective means possible. It starts with political leadership itself, which must identify and list its priorities. Next, every ministry or department is ordered to take a careful look at what it is that they do and ask: How do the priorities of the ministry or department fit with the priorities of the government? How does each of the specific activities being undertaken fit with the ministry's or depart-

ment's priorities? Given the above, are there any activities that are not part of the core responsibilities of the ministry or department? Can any of these noncore activities be discontinued, scaled back or offloaded to other actors? Among the core activities, the ministry or agency must then ask whether each is being undertaken in the most cost-efficient manner while respecting any other values that the government wishes to promote.

Individual programs, program areas and even the entire programming of individual ministries or departments must be periodically reviewed and such reviews ought to be seen as essential exercises. In any large public-sector organization there are bound to be activities that no longer fit the priorities of government the needs of the public, or that can now be done by market actors or community groups. By identifying and terminating these superfluous activities, by focusing assistance on those in need today, not a generation before, organizations can redeploy resources to new or previously unmet needs, or savings can be found that contribute to spending reductions. It is this latter purpose that is likely to be driving the impending round of program reviews across Canada. Ian Clark and Ben Eisen laid out the hard facts in the October 2010 edition of this magazine. While we are not

currently in a crisis, Canada's federal and provincial governments have to begin cutting their expenditures soon and will have to continue cutting over a sustained period of time so as to repay the cash they borrowed to fight off the worst effects of the Great Recession of 2008-09. Clark and Eisen are not alone in making this argument. Recently there have been a growing number of stories in the mainstream media urging Canadian governments

degree that senior political leaders can only superficially oversee the process and only really take account of the dollars saved, not the risks run. Second, the changes are of such a sweeping nature that the program review's appearance of success becomes synonymous with the success of the government. Therefore, it ceases to be a managerial exercise and instead becomes a highly partisan political issue. As a result, insularity develops among the senior political leaders,

of cutting spending so as to reduce the burden of government for provincial taxpayers. What each premier and cabinet as a collective wanted to be informed on was how much money was being saved and the degree to which the burden of government was being lifted. How to cope with the cuts and design a new role for government that better fit the model of a less intrusive state focusing on core mandates was generally left to each individual

minister and his or her public servants. The problem with disaggregation in general, and given these goals in particular, is that coordination between ministries declines. As each ministry sets its sights on retrenching its efforts and refocusing on its core mandate,

there is a strong possibility that things will fall through the cracks.

How do the priorities of the ministry or department fit with the priorities of the government? How does each of the specific activities being undertaken fit with the ministry's or department's priorities? Given the above, are there any activities that are not part of the core responsibilities of the ministry or department? Can any of these noncore activities be discontinued, scaled back or offloaded to other actors?

to address our public deficits. As was the case in a recent piece by Barrie McKenna in the *Globe and Mail*, ominous references are routinely made to the situation of Greece and Ireland and the crisis that awaits Canada's federal and provincial governments if we don't begin to act soon.

The findings and the evidence submitted to the BC Children and Youth Review, conducted by Justice Ted Hughes (published in 2006), and the Walkerton Inquiry in Ontario, conducted by Justice Dennis O'Connor (published in 2002), painfully illustrate what can go wrong. In both cases, the chain of events that ultimately led to tragedy began with crisis driven, whole-of-government program reviews aimed at achieving substantial savings. To be clear, the problem was not that the government of Ontario or that of BC chose to undertake a program review, nor that either government wanted to cut spending or the role of government in our lives. The problem was how it was done.

When program reviews are done on a government-wide basis in a crisis-driven manner aimed at reducing spending above all else, the program review must be disaggregated to such a

as well as the staff members surrounding them, who feel they must suppress or defeat any criticism of the review, no matter how constructive the feedback is. Finally, such massive, sweeping and sudden changes disrupt the working environment so dramatically that public servants cannot implement them and simultaneously continue to serve the needs of the public. They temporarily switch en masse from delivering services to delivering government reform. Drawing evidence from the two commissions of inquiry noted above, we now turn to look at each of the three problems that have been highlighted. We focus on these cases because the evidence is available to anyone who wishes to read the published testimony and reports related to each inquiry. They are certainly not the only cases where a whole-of-government program review has led to the safety and well-being of citizens being placed at risk.

While it is true that a premier and cabinet cannot watch every detail of every file, it is also true that they consider only what they collectively believe are the essential elements of the "big" picture. In both Ontario and British Columbia it is very clear that whole-of-government program reviews were conducted with the aim

For example, in Ontario the decision was made by the Ministry of the Environment to require municipalities to assume a greater role in managing their water supplies and to require them to use private labs to test for quality. If this had been done within a proper regulatory structure and in proper coordination with other ministries, there likely would have been few problems. However, the lack of coordination and the desire to reduce costs and the regulatory role of the province as much as possible — when added to the other deficiencies of the Town of Walkerton's water system and the environment ministry's inspection regime — led to tragedy. Private laboratories see the organizations that pay them as their clients and generally don't inform anyone else of test results. Health officials understood this and recommended that the environment ministry enact regulations requiring private labs to inform the health ministry in the event of an adverse test. But Environment refused, as such a rule was seen to be outside of its core mandate. Therefore, Environment officials argued, it would unnecessarily add to

the ministry's costs and regulatory burdens. Consequently, when Walkerton's water failed a crucial lab test, the task of informing public health officials just fell through the cracks and the resulting E. coli outbreak was far more extensive and deadly than it need have been.

In BC we see a similar situation. As part of its plan to cut costs to pay for a sweeping tax cut, and to reorient government onto a less invasive footing, the province decided to eliminate both its Children's Commission and the Child and Youth Advocate. Previously the commission had reviewed the care plans of children in the charge of the province and investigated childhood deaths. The advocate had acted on behalf of children in dealings with the Ministry of Children and Family Development. The advocate was replaced with a new child and youth officer within the attorney general's ministry. Meanwhile the case review function of the commission was delegated to regional offices of the Ministry of Children and Family Development, and the investigation of children's deaths was assigned to the Coroner's Service (accountable to the solicitor general). Again, these were not necessarily bad decisions. What was done wrong was the transfer of the responsibilities. No one seems to have checked to see if the agencies receiving new responsibilities to protect children were actually performing them and, just as importantly, coordinating their activities.

The Ministry of Children and Family Development, the Coroner's Service and the Attorney General's Office had all just gone through their own core review exercises and substantial budget cuts. They were struggling to meet the challenges they had already flagged as core to their existing mandates. As a result, planning for the transition, communication about it and execution were all poorly handled. There was poor understanding among

the agencies as to who was performing what roles as a result of the restructuring. There was not even an agreement as to when the new regime was supposed to take effect; the Coroner's Service believed it was four months after the actual implementation date, but the Children's Commission began winding down its activities eight months before the date. The magnitude of the chasm between the various agencies charged with protecting children's lives and the crisis in child protection were revealed when the government acknowledged certain facts: as a result

In Ontario the decision was made by the Ministry of the Environment to require municipalities to assume a greater role in managing their water supplies and to require them to use private labs to test for quality. If this had been done within a proper regulatory structure and in proper coordination with other ministries, there likely would have been few problems. However, the lack of coordination and the desire to reduce costs and the regulatory role of the province as much as possible — when added to the other deficiencies of the Town of Walkerton's water system and the Environment ministry's inspection regime — led to tragedy.

of miscues in the transition of responsibilities, no thorough review or investigation had occurred into the cases of 22 children who had died while in provincial care. Second, for much of the period between the date when the reforms were implemented and the date when problems became so apparent that the government was compelled to appoint an inquiry, the new child and youth officer in the Attorney General's Office was not even being routinely informed of children's deaths. Third, the files documenting the cases of 73 dead BC children had simply been lost during the transition and were recovered only after

a general search of the various offices.

In both Ontario and BC the cabinets learned what they had decided they wanted to learn about the state of affairs with regard to reducing costs and restructuring government. What they wanted was budgetary numbers and other data that would allow them to ensure that the cost and footprint of government were in fact shrinking. That was all they had time to consider, given the sweeping nature of the exercises under way. Coping with the changes was left to each individual ministry and the agencies accountable to it, rather than the premiers and their cabinets as a whole. Consequently, neither in Ontario nor in BC does it appear that there was any attempt to ensure communication occurred across ministerial lines so as to ensure nothing fell through the cracks. Those cracks widened into fissures under the weight of restraint and the disaggregated actions being taken to reshape government to make it more affordable.

In both Ontario and BC, there were warnings that problems were likely occurring and that action was needed to protect the citizens' lives and well-being. According to the testimony given at the O'Connor inquiry, Ontario's chief medical officer of health, Richard Schabas, warned the Health Minister about the vulnerability of the province's water supplies and the way other changes in the funding of local public health agencies would increase health risks. The Minister was concerned enough that he had Schabas accompany him twice to the Policy and Priorities Committee of the cabinet. On the third occasion on which Schabas was scheduled to appear, an official from the Cabinet Office approached him after he took his seat and told him that the Premier wanted him to leave. Similarly, in BC, Hughes tells us in his review of BC's child protection system that a former children's advocate, a former children's commis-

sioner and a former provincial ombudsman were so concerned over the state of children's protection that they jointly wrote to the Premier. Receiving no response, they made their concerns public. At this point the Premier agreed to meet with a delegation of concerned experts. By way of an explanation, the Premier said that he had never actually seen the letter from the three eminent retired public servants.

It is difficult to believe that the leader of a province would not want to hear the views of his top medical official on a public health topic. It is also difficult to believe that the leader of a province would not be shown correspondence from well-known retired public servants. That is, it is unbelievable unless a culture of insularity had taken hold in both governments. Once a government decides that there is no value in listening to criticism, there is not much that will shake it out of that mindset other than a tragedy. Whole-of-government program reviews tend to exacerbate the situation. Rather than being a rolling and continuous review of governmental services, they are usually tied to achieving the core mandate of a government, such as cutting taxes or making government less intrusive. When done as sporadic, gigantic efforts, there is no way that the actual reviews can be separated from the government's own reputation with voters. Consequently, such reviews become partisan exercises, rather than managerial ones, with all that this entails in terms of secrecy, the creation of opposition and the determination to make the project appear to be successful, even if the actual results are less than satisfactory. In such a situation governments don't want to hear from critics, and those around them seem to engineer processes so as to allow premiers and their cabinets to avoid them. One of the amazing features of the testimony given to the Walkerton Inquiry was the ratio between the number of documents prepared by officials in the

Ministry of the Environment that showed that following through on the Harris government's policies would lead to substantial risks and the number of such documents that the Premier and his ministers recall receiving. Even when they did recall receiving the warnings, they also seem to have sincerely believed that they had received reassurances that the risks could be mitigated through a redesign of the business process of the Ministry of the Environment. How can this be explained?

At the core of the problem was the way business plans were used in the whole-of-government program review processes in both Ontario and BC. Having been told to cut costs and focus on priorities set by their higher-ups, bureaucrats prepared the best plans that they could so as to cope. These factors were detailed in the various divisional business plans, which then got incorporated into each ministry's plan. To some extent, therefore, they did indeed mitigate the risks entailed. However, this does not mean the plans that the bureaucrats came up with to mitigate

different from what these documents promise: that risks can merely be mitigated. To the degree governments engaging in whole-of-government program reviews insulate themselves from those with critical views so as to press on with what has become a political rather than a managerial project, they are likely to be reading these documents out of context. And read out of context, these documents can lead to misunderstandings that are dangerous to the health of the public and especially the most vulnerable members of society.

As long ago as the 1930s, when Chester Barnard wrote *The Functions of the Executive*, researchers have known that the most successful organizations take account of the entire range of human needs that their employees have. There is a limit to what people can do and asking them to go beyond that rarely works out well. For instance, it is often forgotten that people's ability to cope with change is limited. In his review of children's deaths in BC, Hughes notes that child welfare staff, both in the field and in the ministry offices, had been asked to deal with

The magnitude of the chasm between the various agencies charged with protecting children's lives and the crisis in child protection were revealed when the government acknowledged certain facts: as a result of miscues in the transition of responsibilities, no thorough review or investigation had occurred into the cases of 22 children who had died while in provincial care.

risk were good ones; they were just the best possible. At each level of aggregation the risks seen at the unit level became less and less obvious and the reassurances of mitigation more plausible. Written with a template provided by a central agency, the plans read as logically coherent documents linking overarching priorities to actions, through to outcomes. Worded in an affirmative "can do" style, these documents appear even more convincing still. If read without context, these documents make it very easy to believe that any risks involved can be handled, which is very

too much change in too short a time. There had been changes in the organizational structure of the BC Ministry of Children and Family Development, changes in policy meant to reduce the number of children in care, changes in senior leadership and a need to learn to work leaner, due to a 55 percent cut to the ministry's budget for executive and support services. With so much change under way all at once, the ministry was deflected from its core mandate. Not only was the transition in the investigation of children's deaths mishandled but the policy of reducing the number

of children in care was applied so uniformly that children's lives became endangered. The impact of this whole-sale shock-therapy reform to government was magnified in its consequences, in that every other agency with a role to play in protecting the lives and well-being of the province's children was undergoing its

to ensure that these families were properly supported endangered lives. Failing to give the regional offices time and resources to develop quality assurance regimes multiplied the scale of the problem and level of danger. These proved to be deadly mistakes for some of BC's children, such as Sherry Charlie. The 19-month-old girl was placed in

argued here that periodic program reviews are essential for sound public management. The problem occurs when these goals of cutting spending and making the state less invasive are approached on a government-wide basis. Such projects are too large to be properly monitored, so big that they become synonymous with the success

or failure of the governing party, causing insularity to set in, and so time consuming that public servants are diverted from their ordinary tasks that protect the public. All of this is magnified still further when a whole-of-government

As the experience in Ontario and BC has shown, it is easy for public safety to slip through the cracks during a whole-of-government program review, especially if the drivers for such a review are efforts to find cost reductions and to make the state less invasive and, worse still, if such a review takes place in an atmosphere of crisis.

own top-to-bottom reform. In effect, from 2002 to 2005, the key output of the Ministry of Children and Family Development switched to being governmental reform, and not too surprisingly, the more difficult tasks involved in protecting the well-being of children ceased to be done as well as they might have been with a less distracted work-force.

As a result, the machinery put in place to protect children collapsed. The regional offices of the Ministry of Children and Family Development had difficulty in executing their newly expanded roles. Quality assurance practices such as their new review function for care plans, responsibility for case auditing and investigating serious injuries and deaths took a back seat while the offices struggled with implementing new policies and the significant budget cut for administrative services noted above. Rewriting policy to see fewer children taken into state care, to ensure the preservation of family connections, and to grant Aboriginal communities greater control over child welfare for their communities was surely a wise and humane decision. Even transferring so much of the quality assurance work to the regional offices might have made sense. However, failing to provide the regional offices and their Aboriginal partner agencies with time and resources to train, to create new procedures to screen families and

the foster care of a relative who had well-known anger management issues and a history of perpetrating domestic violence. Sherry was beaten to death by her foster father. In spite of the fact that there was immediate suspicion surrounding the toddler's death, those charged with protecting the welfare of children left her brother with the same man for a further five months. Other similar heart-wrenching stories emerged in the course of the Hughes Review. The stories painfully illustrated the consequences of the systematic failure of BC's child protection regime and how a whole-of-government program review jeopardized the lives of those whom government ought to be doing most to protect.

As the experience in Ontario and BC has shown, it is easy for public safety to slip through the cracks during a whole-of-government program review, especially if the drivers for such a review are efforts to find cost reductions and to make the state less invasive and, worse still, if such a review takes place in an atmosphere of crisis. Yet it must again be noted that there is nothing inherently wrong with a government wanting to work toward a state that costs less and/or is less invasive, or with the concept of periodically reviewing programs so as to enhance the fit between priorities and policies and to boost efficiency. In fact, it has been

review is undertaken in an atmosphere of crisis. Program reviews should be done not on a whole-of-government basis but at known periodic intervals in individual ministries or program areas. This would allow political leaders to carefully monitor progress, reduce the political consequences and associated insularity that develops and allow additional staff to be drafted into the ministries and programs engaged in review.

As noted at the outset of this article, Canada faces an important challenge in terms of our public spending. However, our situation is not so severe that we lack time to take a deliberate and rational approach to the challenge. If protecting the lives of citizens is a priority, then a whole-of-government program review is not the correct process for meeting this challenge.

Daniel Cohn is associate professor and director of the School of Public Policy and Administration at York University; dcohn@yorku.ca. Lorne Foster is associate professor and director of the Masters Program in Public Policy Administration & Law, School of Public Policy and Administration, and Department of Equity Studies at York University; lfoster@yorku.ca. Ian Greene is university professor at the School of Public Policy and Administration at York University; igreene@yorku.ca.