STEEERING AND ROWING IN HEALTH CARE: THE DEVOLUTION OPTION?

By Colleen M. Flood & Duncan Sinclair

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Introduction

Few would disagree with the observation that to govern successfully, those who participate in and benefit from the enterprise being governed must know who is in charge. Unfortunately, this principle is not embedded in publicly-funded Medicare, Canada’s largest and most cherished social program. Take, for example, a patient who is told there is no bed available for her in a hospital in Ontario. Should she direct an enquiry to her physician, to the hospital, or to the government of the day through the Minister of Health and Long-Term Care? To whom does a nurse turn, worried about the impact of a policy of part- as opposed to full-time employment? Does she look to the collective agreement, bargaining agent, hospital CEO and/or Board, or to the Minister of Health and Long-Term Care? Or, in both of these cases, should the protagonists look, in extremis, to the federal Minister of Health? Even in these everyday examples, the answers are ambiguous at best; at worst there are no answers.

Those who govern and those who manage should be accountable for their respective decisions and actions. Provincial governments believe that they are “in charge” of governance and management of health care in their respective provinces and that they are accountable for both through the electoral process. However, that process only provides accountability for the “big picture”. And even then, accountability for health care is intermingled in the picture at election time with how the government dealt with its many other responsibilities. Answering to the electorate every four years or so does not provide accountability for the multitude of decisions that have to be made to ensure an equitable and efficient health care system. A citizen may shift her vote from party to party because of big principle issues like support for two-tier health care or private clinics. Therefore, for such “big picture” principles, elections do provide some measure of accountability. However, a citizen is not likely to shift her vote because her local hospital has not streamlined its information systems or because primary care reform has stalled in her community or because a local gynecologist performs far more caesarean sections than are considered medically necessary. Other, more specific accountability mechanisms are needed that are appropriate to the type of decision-maker and the nature of the decision and/or action whether governance (steering) or management (rowing).

In response to what we describe as the “gap” in governance, management, and accountability in Medicare, many jurisdictions have embraced devolution of management responsibility and authority from central government administrations to regional health authorities, integrated health
systems, municipal governments/county councils, sickness funds – organizations “on the ground” that are closer to the people affected by what are primarily managerial decisions. In Canada, Ontario stands alone in not embracing this initiative. Ontario’s reluctance on this score requires close examination as does the extent to which devolution could contribute to solution of the problems that bedevil publicly funded health care everywhere.

In this paper we propose to:

1. identify and explain the consequences of the governance, management, and accountability gaps in health care;
2. explore devolution and its advantages and disadvantages as one approach to close those gaps in both theory and in experience; and
3. discuss the raft of initiatives of which devolution could form part to achieve workable health reforms.

**Definitions**

We will begin our discussion by clarifying what we mean by governance, management and accountability. These have become popular but infrequently defined rhetorical tools in public discourse. We note also that many government reports have been written stressing the need for greater accountability, but it is rare for a government report to stress the need to improve that government’s as opposed to other actors’ accountability in the system.

1. **Governance**
   The World Health Organization recently emphasized the importance of good governance in health care, the need for “good” and “smart” stewardship on the part of governments, and affirmed that “the ultimate responsibility for the overall performance of a country’s health system must always lie with government.” Other commentators have noted “(d)espite considerable disciplinary and ideological disagreement there has been a common thread of interest in how changes in state behaviour can help to produce better health-related outcomes. Nearly all observers agree that both the configuration and the application of state authority in the health sector should be realigned so as to achieve desired policy objectives…. The intended outcome has strong overtones of desire for what is frequently termed good governance, which in turn involves policy-making that serves the public interest.”
What then is “governance” in health care? We equate governance with leadership, coupled with accountability both for its effectiveness and the performance of the organization led. Governance has to do primarily with defining the vision and mission of the enterprise together with the goals it must meet to achieve both. As it applies to governments and health it includes articulating the values of the health care system and the policies that derive from those values; policies that apply to the choices of decision-makers at all levels in the system. Among the tools of governance are influence, direction, planning, funding, incentives, penalties, and rules, including (for governments) regulation, and legislation. Governments should be accountable both to citizens and patients for their performance as governors. Governments should not try to be managers because a) that is not where their expertise lies; b) there is no effective way to hold governments accountable for the multitude of management decisions required in health care (governments have only to answer to themselves and the ballot box); and c) conflating the roles of governor and manager means that there is no independent oversight of management decisions.

2. Management

Management or administration is different from governance. Whereas governance has to do primarily with what is to be done in accordance with what values, management deals primarily with how policies are implemented and things are done. Management is an executive function with authority for the operational control and direction of activities. It requires a wide range of both general and specialized skills necessary to design and direct knowledgeably the organizational structure, budgeting and operational planning, finances, human and physical resources, internal and external communication, record keeping, evaluation of progress, etc. The skill and expertise required of managers is a different set of skills and expertise from those required on the part of governors. Managers are accountable to governors but also can be more directly accountable to the people affected by their decisions.

In health care, all-too-frequently “provincial governments, through their departments of health, micro-manage their health care systems” in addition to (and sometimes instead of) governing them. In these circumstances the public sector managers concerned are not only accountable to the government, their employer, but also, together with government, to the electorate for managing health care services in the public’s best interest. This conflation of governance and management responsibilities in one body presents a clear conflict of interest; as a result we believe neither function is performed adequately.
3. Accountability

Accountability, which applies both to governors and managers, is the process of being held responsible. It includes evaluating how well or poorly the organization’s actions serve to achieve desired, measured outcomes, both in the short- and long-term.

Accountability may also be described as the level of responsiveness on the part of governments and public institutions to their citizenry. One way to understand the relationship between government and citizens is through the lens of agency theory, with citizens being the principals and the government being their agent.

Agency costs arise when one person or organization (the principal) contracts with another person or organization (the agent) for performance of a service. The performance of this service requires the delegation of some decision-making authority from the principal to the agent. But the agent's interests are not identical with those of the principal. Agency costs represent the loss to the principal from the agent not acting as instructed or otherwise in what the principal would consider her best interests.

Factors reducing agency costs between shareholders and managers in publicly-traded companies are not generally present in the public sector. Consequently, agency problems are a great deal more complicated in the public sector than in private firms, particularly because the burden of any inefficiency is diffused over the many individuals who make up the population served. Citizens have little incentive to band together into powerful lobby groups because their own personal share of the public sector's inefficiency is very small; individuals may decline to take any initiative to lobby for improvement in the expectation that they can free ride upon the efforts of others. In contrast, members of interest groups who have much to gain personally from a particular government decision will have greater incentive to lobby the government but any resultant policy change may not reflect the more diffused interest of the public at large.

The problem of agency cost is closely related to public choice theory. Neo-classical economists assume that market actors are principally motivated by self-interest and public choice theory extends this assumption to the actions of politicians, public servants, and interest groups in the public sphere. However, while many examples of behavior supporting public choice theory can be found, examples of governments and public servants acting contrary to self-interest (or at least appearing not to) may also be found. This suggests that public decision-makers cannot
always be assumed simply to be acting out of self-interest or that what decision-makers perceive as being in their own self-interest may be a much more complicated matrix of factors than simply financial considerations or building or maintaining political power. A sense of public spirit, the law, ethics, culture, moral and social conventions, a desire to embrace good ideas and policy, and ideology likely impact to a greater or lesser degree on the psyches of politicians and public servants just as they do for everyone else.

Pragmatically, criticism from those on the left and the right of the political spectrum with government's performance suggests that public choice problems cannot be ignored when considering the design of a health care system. Balancing the views of both the proponents and critics of public choice, it seems important that there should be, wherever possible, clear financial and political incentives for politicians and public servants to act in the larger public interest. xii Where discretion is granted, as inevitably it must be, decision-making should be as transparent and open as possible.

In the health care sector, governments must be accountable to both citizens and patients for the effectiveness of their leadership, primarily for progress over the medium- to long-term toward realization of an articulated vision and set of values for the system. Managers must be accountable for how effectively they direct progress in their respective areas of responsibility. Accountability for governance occurs through the electoral process (which, although not perfect because of the role of interest groups in influencing decision-making, is still relatively the best means to ensure accountability for this role). But at present in our health care system there is little or no accountability for performance of the management function.

**Governance and Accountability in Ontario’s Health Care System**

This section explores the present lines of responsibility and accountability mechanisms in the health care system, beginning with an account of how current federal/provincial relations in health care distort attempts at rational reform. We proceed then to analyze the present legislative framework for governance of health care in Ontario.

1. Dual Governance in Canada’s Federated Structure

Canada’s federated structure makes the governance and management of and accountability for health care different from those in the United Kingdom and other European countries, New
Zealand, and other unitary states with which health care in Canada is usually compared. It is also different from Australia where there is a clearer division of constitutional responsibilities for the health care sector between the Commonwealth government (responsibilities for physician services and for pharmaceuticals) and the states (responsibility for hospitals, community care, etc.).

The Canadian constitution does not address health and health care as a single subject nor does it explicitly assign responsibility to either of the federal or provincial/territorial levels of government. Judicial interpretation of the Constitution has found health insurance and the delivery of health care to be a matter primarily of provincial responsibility. Nonetheless, the Federal government plays an important role and though its spending and taxation powers raises and transfers funds to provincial and territorial governments to support, in part, the provision of health services to the populations they serve. The Federal government uses its spending power through the Canada Health Act to induce provinces to comply with five criteria in administering their publicly-funded health insurance programs; comprehensiveness, accessibility, portability, and universality, and non-profit administration.

Consequently, whilst the 13 provincial and territorial governments are responsible and accountable for the governance and management of the majority of health and health care services provided to their respective populations the federal government is responsible (and should be accountable) for governing the national system. Does this primarily by upholding and enforcing (through threat of withholding transfers) the values encapsulated in the Canada Health Act. In short the federal government is responsible for maintaining the vision so attractive to all Canadians, regardless of where they live, of a national health care system to which all members of the population have universal and equitable access. Thus, both senior levels of government share now and will continue to share the role of governing Canada’s health care system.

Sharing of the governance role in Canadian health care is not a case of “more is better.” As it applies to health care in Canada the fact that both senior levels of government carry responsibility has led not to stronger governance but to a virtual absence both of governance and effective accountability for the system’s performance, both nationally and provincially. Deficiencies of leadership and accountability featured prominently in the two most recent, comprehensive reports on health care in Canada, Building on Values (the Romanow Report) and The Health of Canadians – The Federal Role (the Kirby Committee Report). Both deal extensively with what
Mr. Romanow refers to as the “jurisdictional and funding issues that have been the focus of intergovernmental debate for much of the past decade.” Provinces claim that all problems in the system are rooted in “under-funding” on the part of the Federal government. The Federal government periodically negotiates further funding arrangements with the provinces, but no changes to the structural status quo are made, and the cycle of protest and appeasement continues unabated. Everyone, distracted by the sideshow of federal/provincial bickering over transfer funds and the media frenzy that ensues, ignores the yawning gaps in governance, management, and accountability.

Long-standing wrangling between the federal and provincial governments over shares of health care financing has left deeply clouded the key issue of who is accountable for what. And the problem extends well beyond the jurisdictions of the two senior levels of government into what is colloquially referred to as the “field of silos;” the many institutions, organizations and individuals that, cobbled together, constitute our health care “system.” In contrast to the private sector where clearly (and legally) accountability rests with a corporation’s Board, health care in Ontario does not have a Board of Directors. Indeed, in some of its parts, hospitals for example, final responsibility lies somewhere between the hospital board and the Ministry of Health and Long-Term Care, with the Ontario Hospital Association’s collective functions making the lines of responsibility even more fuzzy. In others, physicians’ offices for example, no policy-making body comparable to a Board of Directors exists.

Health care is often portrayed as being in “crisis” both in Ontario and across Canada. This crisis manifests itself in packed emergency rooms, growing waiting lists, increased public concern about the quality and timeliness of care, and continued complaints from governments over the level of public resources required to sustain the system and meet growing expectations. “Crisis talk” is used by physicians, nurses, hospitals, and other providers seeking greater funding from provincial governments. In turn, crisis talk is used by provincial governments seeking greater funding from the federal government. Crisis talk is also extremely popular with the media, because it makes for much more scintillating front-page headlines than stories about the smooth on-going operation of the health care system. The end result is that the recurrent political debates are reduced, yet again, to issues of money with everybody blaming all the problems of the system on the lack thereof. We believe, however, that the “crisis” in health care experienced in Ontario has much less to do with funding and much more to do with an absence of effective leadership – of governance that is clearly identified to be “in charge and responsible.”
2. The Legal Framework for Governance in Ontario

A recent review of the legal framework for governance reveals there are at least 23 pieces of legislation affecting the roles and accountabilities of five key decision-makers in Ontario’s health care system. These five key decision-makers are the Minister of Health, the Ministry of Health, public hospital boards, Community Care Access Centres (that purchase home care services), and physicians (whose decisions regarding treatment and referral are a key factor in determining total cost and utilization in the system). The legislation reveals a mishmash of overlapping responsibilities. Little attention has been paid either to articulating clearly spheres of responsibility or to identifying areas of competency, lines of accountability, and incentives for performance.

In some places the legislation, for example the Health Insurance Act, validates and underscores the vision of publicly funded Medicare as a simple insurance program. In the 1960s, when the foundations of Medicare were being laid, it was thought that governments would act like private indemnity insurers, reimbursing physicians, hospitals and other institutions for any and all services provided. It was assumed that no service would be provided that was not “medically necessary.” But this vision of Medicare is outdated. In both public and private health spheres there has been a radical shift in how the role of the health insurer/payer is conceived in response to concerns of moral hazard and rising health care costs. In the private sector, there has been the rise of managed care where insurer/payers actively intervene, structure, monitor and manage the care that physicians and others provide to patients. In the public sphere, much more attention has been paid to the level of resources invested in the system given the understanding that increased spending is not necessarily correlated with improvements in health. Thus in both the public and private spheres, the role of insurer is much more than simply a payer for care. Good governance and careful management of the system or systems are needed to ensure efficiency. The legislative framework in Ontario does not reflect this paradigm shift.

Devolution – the Case and Experience

We now turn to explore what role devolution may play in mitigating some of these difficulties.
Devolution to subsidiary agencies is certainly not a new idea; it has been popular in policy circles for many decades. As far back as 1964 the Hall Commission identified regionalization of responsibility for health care services as a good idea; it was endorsed as a federal objective in 1969, the same year in which the Ontario Council of Health developed a model for decentralizing health services provincially. More recently, in 1993, the Premier’s Council on Health, Well-Being and Social Justice\textsuperscript{xxx} reviewed various models of devolution and decentralization. But no action was taken to implement that (or any other) model of devolution and Ontario remains, in effect, Canada’s control group in the devolution movement. There is now substantial experience with devolution/regionalization of responsibility for health care services in other provinces and internationally from which Ontario can learn.

We begin by reviewing the advantages and disadvantages of devolution, largely from a theoretical perspective, although informed by experience within Canada and internationally. We then proceed to analyze the devolution experience across the other provinces of Canada, identifying successes, failures, and barriers to successful reform.

1. The Advantages of Devolution

The advantages of devolution, the transfer of power and authority to regional authorities or other bodies (for example, integrated groups of physicians, nurses and other providers), are listed below.

1. Responsiveness to Local Needs

1.1 Decision-making is shifted closer to those most affected and, consequently, there is more direct accountability. Those affected (patients, providers, and members of the general public – prospective patients and taxpayers), can bring their views more easily to the attention of those making the decisions than they can to a more distant, central authority. The closer and more connected such decision-makers are to the citizen’s community the easier it is for citizens’ voices to be heard by decision-makers. Citizens know where and with whom “the buck stops.”

1.2 Devolution increases the “stake” or sense of ownership of those affected and their representatives both in the decisions made and in their outcomes. This is especially true when planning is done and implemented on a community or regional level.
1.3 Within centrally determined limits of national and province-wide equity (a central governance responsibility), specific health services can be more closely tailored to meet identified local/regional needs. In a diverse province like Ontario this can diminish the “one size fits all” problem.

1.4 It is possible that different, more flexible organizational structures can evolve to support devolved decision-making.xxii

2. Matching Capacity, Responsibility, and Accountability

2.1 Devolution shifts accountability primarily for managerial or operational decisions about health services delivery away from governments. It is not appropriate for governments to make or to be held to task for the myriad small (in the political sense but nonetheless critical) decisions that have to be made in health care. A provincial government should instead be held accountable for governance decisions and for ensuring that the bodies to whom it has devolved managerial responsibility are meeting well the particular needs of the people they serve.

2.2 Most importantly, devolution helps to install a series of checks and balances into the health care system, allowing a government to monitor the performance of subsidiary agencies that manage the system rather than attempting to fulfill simultaneously the conflicting roles of regulator, manager and purchaser. The system’s weakest link is its failure to hold accountable in any effective way the managers of the health care system. Putting the management function into a separate organization allows government to monitor the performance of arms-length management agencies.

3. Integration of Services

The problem of “silos” of funding, with separate budgets (and different payers) for hospitals, for home care, for physician services, for prescription drugs, for drugs consumed in hospitals, etc., etc., has long bedevilled health care in Canada. The problem is that decision-makers have neither motivation nor capacity to make rational decisions about deploying resources from one “silo” to another. In theory, of course, it is possible for a Ministry to break down silos and shift resources, but in reality this is almost impossible as decision-makers within the Ministry are mired in a web of relationships with different interest groups and find it extremely difficult to break long-held political accommodations. The process of devolving fiscal responsibility to regional authorities or other bodies provides a window of opportunity to merge pre-existing silos of funding into the
hands of one decision-maker who is then empowered to allocate resources rationally across a
variety of health care needs, e.g. shifting resources away from physicians to nurse practitioners,

4. Depoliticization

4.1 For governments, one of the most attractive potential benefits of devolution is the prospect of
depoliticising some of the most difficult rationing and prioritization decisions that have to be
made in health care. It is likely that this claim will be met with skepticism, particularly in Ontario
given the present government’s experience with devolution to Community Care Access Centres
(CCACs), arm’s length organizations created by the Ontario government to fund and purchase
home care services from (it was hoped) competing providers.

As the CCACs represent Ontario’s only experience with devolution, they warrant some comment
here. The response of many CCACs to the challenge of managing within limited budgets was to
blame the provincial government for reduced service levels by pointing out publicly that their
requests for additional funding were denied. As a consequence, the provincial government has
recentralized many of the management responsibilities. Should this experience be viewed as
conclusive evidence of the perils of devolution? The problem is not with devolution itself but the
problem of “lip service” devolution. There was no framework for coordination between CCACs
and the hospitals whose discharged patients created increased demand for home- and long-term
care. Nor did the CCACs have any control over the rates of pay of those who provided the
services for which they contracted. With no legislative framework on which to rest their
authority, from their inception CCACs did not regard themselves as genuinely independent
decision-makers acting within a policy framework set by government. Nor did the communities
they served. The CCAC experiences also raises the issue of misalignments in mandate,
accountability and budget – a process Steven Lewis refers to as “asynchronous devolution.” The
CCACs were expected to be accountable simultaneously to the citizenry and the government and
(arguably) this mandate was bigger than that which could be served by their budgets. Thus the
CCAC experience should not be used in the case against devolution per se but rather of what not
to do when devolving responsibility in health care.

Devolution to RHAs in provinces other than Ontario remains a “work-in-progress.” As discussed
more fully below, in no province does devolution of operational responsibility for health care
extend to anything like the full range of services provided, region by region; in none, for
example, are the rates of compensation for doctors and nurses (or other health professionals) negotiated by RHAs. As a result, it remains easy for RHAs, the media, and citizens alike to shift political opprobrium centrally to Ministers of Health and the government when things go wrong (or not right). The higher level example of blame shifting between the provincial and federal governments is not lost on RHAs!

But as demonstrated, however imperfectly, by school boards, municipalities, children’s aid societies, public health authorities, and other subsidiary bodies, when their respective responsibilities are made clear, devolution can work. Devolution can diminish and diffuse the partisan political implications of the great majority of managerial or operational decisions all of which are now directed centrally to government in Ontario. What is and will be needed for devolution to work is to move past the “blame-game” and to foster trust and partnership between governments and the agencies to which they devolve managerial responsibilities.

2. The Disadvantages of Devolution

1. Additional Bureaucracy

1.1 Unless government ministries are restructured and “downsized” to reflect the devolution of service delivery management, it can result in the establishment of an additional layer of bureaucracy and higher administrative costs associated with the governance and management of health care. Government bureaucracies tenaciously resist real deployment of resources to arm’s-length institutions. Moreover, periodically arguments of excessive bureaucracy are used to justify eliminating the arm’s-length institutions (as opposed to redeploying resources from central government). For example, the recently elected Liberal government in Quebec has announced plans to “to eliminate regional health boards and replace them with a less bureaucratic structure.”xxxiii The assumption is that bureaucracy is only associated with costs not benefits. The Quebec government, rather than adopting the mantra of less bureaucracy and being enticed by the prospect of “doing something” in health care even if it is but another redisorganization should ask itself whether the benefits gained from devolution outweigh the additional administrative costs?

In any event in many Canadian provinces the process of devolution of managerial responsibilities to RHAs has been accompanied by a significant centralization of managerial responsibilities through the elimination of hospital boards. Thus, in total administrative costs may not have increased at all. However, as we discuss more fully below, we do not recommend that regional
boards in Ontario necessarily assume managerial responsibilities for hospital boards and thus there will be additional administrative costs if our proposals were to be adopted. But as stated earlier, how much more will depend on the degree to which the bureaucracy of the Ministry of Health and Long-Term Care were to be “downsized”.

2. Technical Funding Issues and Risk Information

2.1 When some regions uniquely offer the institutions and expertise necessary to provide province-wide or even nation-wide highly specialized services (like organ transplantation or very sophisticated paediatric services), appropriate governance and funding of those services must be done at a provincial level where accommodations can be made to ensure access to specialized services for people in regions where those services are not offered.

2.2 There is no conclusive evidence regarding what is the optimal size for a regional health board; there is enormous variation. In England, the new purchasing agencies “Primary Care Groups” service approximately 1 million people each. But England does not face the same challenges of physical geography as does Canada. Within Ontario, establishing and maintaining a reasonable balance among regions may be difficult, especially when some (like Toronto), if established on a geographic basis, would dominate others (like north-eastern Ontario) and, in any case, would be too large on the basis of the population served to achieve the advantages of devolution. We recommend, given Toronto's population density and the specialized services available there, that a different management structure be embraced. As we discuss further below, we recommend gradual implementation of a system of competing integrated health systems in Toronto with specialized services being still managed provincially.

2.3 Regional boundaries are difficult to establish, especially in relatively highly populated areas like Toronto with good transportation systems. People can, theoretically, shop from region to region in search of services to which particular regions have decided to give priority, creating the problem of inter-regional transfers of funds in proportion to the delivery of services to people from other regions. This “problem” may be seen as an advantage if reform contemplates (as we do) encouraging competition among integrated health systems and eventually allowing patients to “exit” with a risk-adjusted share of public dollars from purchaser to purchaser.\textsuperscript{xxiv}

3. Loss of Monopsony Purchasing Power and Central Control
3.1 Governments may be concerned about potential diminution of their ability to co-ordinate the provision of services centrally (something we consider almost impossible to do in any case). There would be still the potential for central direction in certain cases to ensure co-ordination. Moreover, regional health authorities will seek to co-ordinate their activities, if not in pursuit of the larger public interest, then in pursuit of their own self-interest.

3.2 The bargaining power that accrues from being a single large buyer of health care may be diminished. But it is not in every market, however, that there will be problems of supply side monopoly\textsuperscript{xxxv} and joint purchasing agreements or associations could be developed where necessary to minimize this risk.

4. Devolving Misery

4.1 People may fear that after devolving managerial responsibility together with an “envelope” funding, government will avoid responsibility for further increases in health funding, instead blaming the devolved authority for poor management in the event of growing waiting lists or other problems.\textsuperscript{xxvi} Thus funding formulas and mechanisms for acceleration for funding must be fair, transparent, and sheltered from short-term political decision-making.

5. Difficulties Recruiting Expertise

5.1 As with District Health Councils, Community Care Access Centres, and School Boards, the nomination, selection, appointment, and/or election of known and respected leaders from the community concerned to serve on the boards of RHAs can be difficult. No reputable person with vision, experience, and expertise will participate in much less run a lame-duck organization. Thus the difficulties in recruiting expertise are directly linked to the structure of RHAs and whether decision-makers are accorded real power (as opposed to being puppets of the government), real responsibility, realistic mandates and budgets, and strong financial and professional rewards for achievement. Health care is the biggest industry in Ontario and like any industry needs talented management in order to succeed. However, because this is a public-sector industry there is a perception that any and all spending on management is wasteful. For the publicly-funded system to thrive we need to pay the best and the brightest to run it. Understandably, the public are concerned that political cronies will be appointed to well-paid jobs in the public service. These kinds of fears must be allayed by more transparency in the hiring process and by direct reporting on the part of RHAs to citizens on performance – so citizens can see that expenditures on management translate into real benefits.
6. Political Visibility/Lack of Public Acceptance

6.1 The establishment of new management agencies can have the potential of diminishing the political visibility of ministers and elected members of provincial/territorial legislatures. This has its “upside” and “downside” depending on how well or poorly health care delivery is popularly regarded in the region concerned.

7. Political Opposition by the Hospital Boards and Physicians

In Ontario, the two main opponents to devolution to RHAs will be hospital boards (who fear a loss of control) and physicians, if the funding envelope for physicians’ fees is also devolved.

Devolution of management control from ministries to RHAs may also involve centralization of administrative control of hospitals to RHAs. This, however, is not necessarily required with devolution and, indeed, many jurisdictions have experimented with the benefits of “splitting” the role of RHAs as the purchaser of health care services and retaining (competing) hospitals as providers. Thus devolution of managerial powers to RHAs does not mean that all providers of care should be consolidated into and managed by a RHA. The long tradition of voluntary governance of locally owned hospitals and other institutions and the entrepreneurial potential of independently governed organizations and practices should not be discarded so easily. What will be key is that RHAs receive funding for all hospitals services and that hospital boards negotiate performance agreements with and are accountable to the RHAs rather than to provincial ministries of health. RHAs or their equivalent should have the latitude to deal with hospitals and other providers in their regions in ways that best optimize the management of service delivery in accordance with the governance objectives articulated by the provincial governments.

Some physicians will be opposed to the transfer of funding envelopes for their services from provincial governments to RHAs. However, negotiations between the ministries of all provinces and physician associations regarding fees and what is in and out of the Medicare basket is in gridlock. Nearly everyone in policy circles agrees that the fee-for-service system of payment as it currently operates in Canada has to be changed so that physicians and other providers have incentives to provide the right mix of quality and volume of services. RHAs or other devolved decision-makers will be better able than governments to tailor flexible payment structures to meet local needs and may be able to broker new accommodations and relationships with providers that better serve the public interest.
3. Weighing the Pros and Cons of Devolution

We do not wish to under-represent the technical nor, in particular, the political challenges associated with devolution. Nor is devolution THE solution to all the problems inherent in publicly funded health care. On balance, however, devolution is a critically important step in untangling governance from management responsibilities and strengthening lines of accountability. The most powerful advantage of devolution is that it locates the locus of responsibility for the management of health care delivery at the “work face” where accountability to the people served can be most directly and satisfactorily discharged. It also frees provincial governments to concentrate their efforts on governing a functional health care system. It is a misnomer to characterize the present dysfunctional collection of health care programs as a system. A commitment to devolution is the first step to enable governments to steer rather to row in health care. Governments may argue that devolution does not work because the citizenry will always hold them to account. To be clear, the public will indeed look through the veil of devolution and hold the provincial government accountable where devolution is either a) incomplete and/or b) a sham (as with CCACs).

2. Devolution in Canada

Quebec was the first province in Canada to introduce managerial responsibility to RHAs. Since that time, and especially during the early 1990’s, eight other provinces and one territory have embraced devolution to RHAs. Here we briefly describe devolution in Alberta, British Columbia, Nova Scotia and Quebec, representing a cross-sample of approaches across the country.

Alberta - Following a review in 1993, RHAs were first established in 1994 with the goal of ensuring their responsiveness to citizens and consumers. Further plans for improvement were announced in 2000, 2001, and 2002. Prior to 2003, there were 17 RHAs in Alberta, with between 9 and 15 members each. On December 19, 2002, the Alberta government announced the boundaries of nine new RHAs, with larger authorities absorbing smaller ones. The new boundaries came into effect on April 1, 2003. These RHAs serve catchments of between 66,156 to 1,085,496 people. Interestingly, Alberta shifted from appointing members of RHAs, to their election, and has now returned to appointment.
**British Columbia** - A Royal Commission in 1991 and extensive consultations with provincial residents led to the publication in 1993 of a policy paper called *New Directions for a Healthy British Columbia.*  
A further review in 1996 focused on streamlining governance structures and allowing for differences in urban and rural areas. The revised plan was called *Better Teamwork, Better Care.* In 1997 British Columbia transferred authority for the governance and management of most health services to a multitude of health service organizations.

In December of 2001, the provincial government restructured the system, replacing its 52 health authorities with one Provincial Health Services Authority and 5 (regional) Health Authorities serving 16 Health Service Delivery Areas. These RHAs serve catchments of between 320,000 to 1,300,000 people.

**Nova Scotia** – Following reports in 1989 and 1990, Nova Scotia fixed on a goal of devolving (some) managerial authority to RHAs. In 1994, the government introduced 4 Regional Health Boards (RHBs) and a number of Community Health Boards. In the fall of 1999, a new government planned the replacement of the four RHBs with nine new community based volunteer District Health Authorities. On January 1, 2001 the province replaced its 4 RHBs with 9 District Health Authorities, serving catchments of between 34,000 and 395,000 people.

**Quebec** – Between 1989 and 1992 Quebec established Regional Boards of Health and Social Services (Régies régionales de la santé et des services sociaux, or RRSSSs). There are currently 18 RRSSSs that are the product of converting then existing regional councils into regional boards, and also of transforming those entities from advisory groups to boards with decision-making powers. Their establishment was accompanied by the 1991 launch of a government initiative to address a number of specific health and social service problems. These RRSSSs serve catchment populations of between 20,000 and 1,851,300 people. In the run-up to the 2003 Quebec provincial elections, the Quebec Liberal party, which ultimately succeeded in its bid for government, announced plans “to eliminate regional health boards and replace them with a less bureaucratic structure.”

Our review of the evidence (primary and secondary literature) shows that across Canada devolution has been a mixture of successes and failures. The failures can be attributed to 1) rhetorical rather than substantive devolution; and 2) that no health authority receives funding for
the key elements of the health care system (e.g. physician services, pharmaceutical services, etc.). These failures are described in greater detail below. The greatest achievements of the devolution process have been realized more recently and focus on the significant strengthening of accountability frameworks.

i. Rhetorical Rather than Substantive Devolution
In most provinces devolution has occurred in form rather than substance. Many health authorities remain subject to micro-management by the provincial Ministry of Health thus making what they do more administrative than truly managerial work.

RHAs, by and large, are still restricted to line-by-line budgets negotiated with and set by the Ministry of Health concerned. They have some latitude, to be sure, but relatively little capacity to shift funds among elements and functions, from hospitals to home care or hospital care to primary care, for example.

Lewis et al, xliii in a survey of regionalization in Saskatchewan, found that “respondents expressed concerns about the degree of boards’ autonomy from government in making decisions” and that there was a “lack of clarity in the division of authority between boards and Saskatchewan Health.”xliv Other problems identified by the respondents in the Lewis survey include: a perception that the board had legal responsibility for things over which it had insufficient control; the government had laid down restrictive rules; and board members felt they had less authority than expected when the districts were formed.xlv

This trend continues to be seen in the results of a study conducted in late 2001, early 2002 by the Canadian Centre for Analysis of Regionalization and Health (CCARH). In its survey of CEOs, board members and Ministry officials, the CCARH found that only one-third of CEO and Ministry respondents felt that the division of authority was clear, while board members were evenly divided on the question of clarity.xlvi A majority of board members and CEOs believed that the RHAs had less authority than they should and approximately 70% felt they were too restricted by government rules.xlvii

2. Failure to Devolve Funding for Core Sectors
No province has devolved to RHAs fiscal responsibility for the full spectrum of health services. Most importantly, no RHA participates in, much less determines, either compensation levels or
the method of its distribution to physicians practising within its region and in the institutions and organisations for which it is responsible. Thus RHAs do not have any funding or accountability relationship with physicians, who as gatekeepers to the health care system, effectively determine what range and volume of health care services are used. Neither do they have access to the all-important lever of wage rates for nurses and other health professionals the payment of whom constitutes the predominant cost element throughout all components of the health care system. No RHA has responsibility for managing funding for provincial drug plans. Services for patients diagnosed with cancer or mental disorders are also outside the ambit of most regional health authorities.

No RHA has responsibility for management of the “whole loaf.” This, of course, constitutes a major managerial problem in such an interconnected enterprise as health services. Without the capacity to co-ordinate all key elements of the “system” RHAs are not able to manage effectively those elements over which they do have responsibility. The orientation of a system where responsibility for key elements of a system are divided among different decision-makers always tends toward the delivery of services rather than to policy issues and health outcomes.

To be clear, RHAs need control over those elements of the system which are possible to integrate at a regional level. There are some areas of responsibility that must be coordinated at a provincial level. Very sophisticated and expensive equipment (radiation therapy machines, for example) and services (such as open-heart surgery), require (at a minimum) province-wide management to achieve both inter-regional equity and the efficiencies that come from economies of scale. This has long been recognized in Ontario and is reflected in such subsidiary agencies as Cancer Care Ontario and the Cardiac Care Network that now carry (partially) devolved system-wide responsibilities. RHAs/integrated health systems should collectively assign to such agencies responsibility for coordinating the inter-regional management of selected services that are better dealt with centrally than on a decentralized, regional basis.

3. Accountability Frameworks

The success story of devolution across Canadian provinces is just beginning to emerge and it focuses on improving accountability mechanisms.

In Alberta, all RHAs are required by law to develop a regional health plan. Each plan must: state how the RHA will meet (and measure its performance in meeting) its statutory
responsibilities; provide for establishing one or more community health councils (CHCs); define
the role of the CHCs (as an advisory body to the RHA, contracted by the RHA to provide
services, or both); incorporate information on the health services to be provided in the region;
and incorporate any other information as the Minister requires. At any time the Minister may
require a RHA to produce a report on its activities and all must produce annual reports to be
tabled in the legislature.

In Nova Scotia, the Minister of Health appoints a board of directors to administer, manage and
direct the affairs of each district health authority (DHA). Each DHA must “provide information
to the public about … the operations and activities of the authority” and must also submit each
year an annual report that includes “results achieved by the authority with respect to any
performance objectives established for the authority.”

The Capital Health District Health Authority (CHDHA) in Nova Scotia has created an
“Accountability” section on its website because “[p]eople deserve to have the best information
that they can about how effectively the health care system is using public money, about meeting
the public’s needs, and about making important improvements in treatment and care.” While
still ‘under construction’ as at the date of this report, the CHDHA states that the section will
feature a “Daily Review”, which is a ‘snapshot’ of daily operations in facilities throughout the
district, and also a quarterly report on “Operational Measures Indicators”, which include:
responsiveness, system competency, community/client focus, and work life.

In BC, the Ministry of Health Planning (MHP) and the Ministry of Health Services (MHS) are
responsible for the overall planning and direction of the health care system, including holding the
RHAs accountable for their performance. The relevant legislation requires the BC RHAs to
develop regional health plans and that they report to the minister on their activities in pursuance of
their respective plans. Of particular interest in BC are the performance agreements established
between the Ministry of Health Services and the RHAs. In 2002, the MHS and each RHA signed
performance agreements requiring each RHA to account for the delivery of patient care, health
outcomes and how health dollars are spent. The performance agreements are intended to be key
documents outlining how governance, accountability and performance will be connected and
managed within health care system.
A report by the BC Auditor General notes that several other jurisdictions (Manitoba is one recent example) have used or are using similar sorts of performance agreements; Saskatchewan has used them since 1997/98; New Zealand has ‘Crown Funding Agreements’; the United Kingdom uses 3-year performance plans; and New South Wales uses performance agreements. The performance agreements introduced in British Columbia are intended to address many governance-related issues, including roles and responsibilities, relationships and accountabilities. Their planned effect is to indicate who is in charge, who sets directions, who makes decisions, who monitors progress and, ultimately, who is accountable. An example of a performance agreement is attached as Appendix 1.

The BC Auditor General, in a recent report, comments that he supports “the concept of increasing accountability through performance agreements” as his office has previously “expressed concern about the lack of accountability in the health system”. Looking at the BC agreements from the perspective of governance, accountability and performance measurement and reporting, the Auditor General concluded that the agreements “need to evolve considerably before they can be regarded as effective tools”. With some recalibration, the Auditor General believes that performance agreements “should become the key accountability documents between the ministry and health authorities.”

The key recommendations from the BC Auditor General’s Report are:

1. the purpose of the agreements should be clearly defined. They should clearly outline who is to be held accountable for the performance expectations within the regional health care system;
2. the agreements should set clear objectives;
3. a more collaborative approach to drafting is required with a timeline that allows for greater participation by the RHAs. This drafting should be part of the ministry and health authorities’ ongoing management and decision-making processes;
4. performance measures should be confined to those critical for decision-making and linked to objectives and improvement priorities; and
5. reporting requirements should be based on decision-making needs.

The Auditor General also noted that other jurisdictions with similar agreements have independent review and audit processes to monitor these relationships and he urged the Ministry to consider instituting similar controls.
Recommendations for Closing the Governance/Management/Accountability Gaps – 
Devolution as Part of the Solution

We now turn to our recommendations for reform in which devolution forms part of the solution.

1. Refocusing the Debate (at least a little) from Money to Governance

It is important to clarify for everyone concerned, governments and citizens alike, that the “crisis” in Canadian health care has its roots in deficiencies in governance, management, and accountability and not solely in funding. Important as it is, funding is but one of many functions that come with the responsibility for governance of the health care system. Yet wrangling about money and the need for more\textsuperscript{ix}, now the primary to exclusive focus of discussion, has had two deleterious effects at least. First, it has created the false impression that health care’s problems can be resolved by spending more money on it. Second, it has deflected attention away from the more fundamental issues of national and provincial/territorial governance of the system, management that simultaneously achieves both inter-regional equity and accommodates differences in diverse regional needs, the need for measurable outcome and productivity measures, effective health information management, and, very importantly, accountability to those served by the health care system and who pay its bills whether through taxes or out-of-pocket.

We appreciate that it will do no good merely to add our voices to the Senate Committee, Mr. Romanow, and many others who have implored the provincial/territorial and federal governments to stop their public wrangling over funding health care. Instead we recommend that both federal and provincial governments finally acknowledge that many of the problems in health care stem from their own respective lack of accountability for the decisions they make. Specifically we recommend:

THAT while continuing to discuss matters related to its funding, the two senior levels of government publicly announce their collective determination to address current functional deficiencies in the governance, management, and accountability of health and health care services from a country-wide perspective and in each province and territory.
2. Clarification of Governance Roles

Clarification of the governance roles of both levels of government in Canadian health care is the first step to accountability. What role should the Federal government fulfill? Mr. Romanow’s extensive consultations showed that Canadians are deeply committed to continuation (and expansion) of a publicly-funded national health care insurance system that adheres to the principles of the Canada Health Act: universality, accessibility, comprehensiveness (including expansion into home care and catastrophic drug costs), portability, and non-profit administration. But, important as they and the values they represent are, the principles of the Canada Health Act are themselves too general to be useful in holding the federal government accountable for its role in governing health care in Canada as a national system. They and other principles, such as how comprehensiveness should be defined as we enter the 21st century, must be made more explicit and converted into national policies, the implementation of which can be measured and evaluated on a regular, preferably annual basis. This would provide more system-specific accountability of how well or poorly the federal government is meeting its governance responsibilities in health care than is possible with elections every four years or so.

We recommend:

THAT the Ontario government propose that the proposed National Health Council be charged jointly by both levels of government with developing and recommending the adoption of national policies to make explicit and measurable the governance responsibilities for health and health care of the federal government.1

We recommend also:

THAT the Ontario government propose that the federal government develop appropriate plans, together with specific goals and objectives, to discharge its other responsibilities in health care including that of providing predictable fiscal transfers to the provinces and territories. Such plans should be filed with the National Health Council.

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1 For some this would not be a wise requirement to put upon the Health Council for they would see this as involving the Council too closely with the existing system, rather than allowing it to be a clear, fearless analyst, critic and exhorter. However, we fear the reality is that the Health Council will not be given either the mandate, independence or powers to be completely outside the system. Thus we think the Council
Turning to the governance role of the provinces and territories, within the policy framework of a national health care system, substantial variability is essential to accommodate the wide differences in population, geography, cultures, traditions, and other characteristics between and within Canada’s provinces and territories. Ontario government’s responsibilities should include articulation of the particular vision and mission for health care throughout the province and the development of related short-term (annual) and long-term plans with measurable goals and objectives to be achieved within defined time-lines. Another is for development of a policy framework encapsulating the particular values Ontario requires its health care system to exemplify and use. A third responsibility is to develop measures of how the government should be held accountable, preferably on an annual basis, for how effectively it is meeting its governance responsibilities.

Accordingly, we recommend:

THAT the Ontario government develop its vision of and mission for health care, the values that must apply throughout the system, annual and longer term plans incorporating goals and objectives to be achieved within defined time frames, and measures by which progress toward them can be evaluated. The plans and monitoring of progress toward their realization should be made transparent by tabling in parliament every 6 months comparative performance data.

3. Establishment of Regional Health Authorities/Integrated Health Systems.

Ontario continues to centralize its management/operational functions in the Ministry of Health and Long-Term Care both in Toronto and its regional offices. As argued above, there are strong arguments in favour of delegating or devolving managerial responsibilities to regional, community-based organizations, which potentially will be much better able to discharge the detailed and sophisticated responsibility of managing the provision of health care services.

Apart from the Toronto conurbation, Ontario lends itself to the establishment of geographically defined regional health authorities – North-western Ontario, North-eastern Ontario, South-western Ontario, South-eastern Ontario – on the model employed in other provinces, especially recently since their number has been reduced and size increased in several. For the “Golden
Horseshoe” (say from Hamilton to Oshawa and north to Barrie) and possibly for the other major cities of Ottawa, London, and Windsor, advantage should be taken of an alternative organizational form – integrated health systems (IHS). These are organizations of providers – hospitals, CCACs, nursing homes, primary care groups – the whole range of institutions and organizations of providers necessary for and prepared to take on the responsibility of providing a spectrum of health and health care services to a population defined by a roster of individuals and families who contract with the IHS for their care. IHSs could evolve to cover the full spectrum of health and health care services. Fundamentally, IHSs could be like RHAs, the difference being that the population they serve is defined not by geography but by the competitive registration or enrolment of individuals and families. The funding provided is based on the size of the register/roster of each IHS, which is itself determined competitively against other IHSs on the basis of its enrolees’ satisfaction with their accessibility to and the quality of health services provided. We envisage that groups of partner agencies/institutions etc. would apply to government for the authority to operate as an IHS. Whereas RHAs are top-down, in that they are formed by government decision and edict, an IHS is bottom-up in derivation.

Obviously, IHSs can only be developed in areas where the population is sufficiently large to permit competition between two or more of them. In addition to the advantages that derive to the population from competition for patient satisfaction, competitive IHSs provide the potential to set “market”-derived standards of performance (including patient satisfaction) against which the standards achieved by RHAs can be measured.

In response to our recommendations, some may argue that there is little evidence that competition for patient satisfaction, which *de facto* exists among all fee-for-service private medical practices, actually makes much difference. What is needed are comprehensive and publicly reported performance measures. We agree that measures of this kind are by far the most effective way to encourage under-performers to improve their game. We think nonetheless that patient satisfaction is not an irrelevant measure; it should be both part of and informed by other measures in the performance measurement basket. We are cognizant of the fact that experiments with competition in other jurisdictions having not always been successful (although it is extremely difficult to appropriately assess these experiences given that change is often heaped upon change and redisorganization upon redisorganization). We also realize many technical issues require resolution before meaningful competition could occur between IHSs and, in particular, that it will be some time before there is the information needed to fairly calculate
risk-adjusted per capita payments. But nonetheless competition could prove a strong force for change and a strong motivation to gather the information needed and to create the performance measures that we presently lack. We can’t encourage competition because we don’t have the appropriate information systems and performance measures but in the absence of encouraging some form of competitive reform we may never have the necessary motivation within the system to build those information systems and debate the performance measures. This Catch-22 situation means that competitive reform will never be able to be an unadulterated success story, the process of change will be incremental, decision-makers will have to learn as they go, and because competition can upset existing allocations of public resources there will always be complaint and dissent to accompany the process.

We recommend:
THAT the Ontario government pass legislation to establish RHAS and (incrementally) IHSs, and

THAT it devolve, in stages, responsibility and authority for oversight of the management/operations of health and health care services, beginning with geographically defined RHAs in North-western, North-eastern, South-western, and South-eastern Ontario, and proceeding over time to IHSs in the province’s more densely populated urban centres where competition across part or all of the spectrum of health services is possible.

4. Clarification of Management Roles
After defining its own role in governance of health and health care services and developing policies to guide implementation of its short and long-term plans, the next essential step is for the Ontario government to define the responsibilities and authority of RHAs and IHSs.

We recommend:
THAT the Ontario government define the roles of RHAs and IHSs in implementing the government’s plans to achieve the vision and fulfil the mission established for the health and health care system throughout the province.

5. Integration of funding
As with the division of responsibilities for funding health care between the federal and provincial/territorial governments, so it is with money flowing in different streams between the provincial/territorial governments and RHAs and/or providers. Failure to integrate that flow into a single stream leads inevitably to “cost shifting” from those sources controlled peripherally to those controlled centrally and vice versa. Similarly, it creates the opportunity to blame all deficiencies on a shortage of resources and, naturally, those who control the revenue streams deemed to be deficient. Mr. Romanow once referred to this as the “name, blame, shame, game”.

Keeping separate various streams of funding for, for example, acute care hospitals, physician recompense, home care, mental health services, and so on makes sense if these several contributors to the health care “system” function independently and regard one another as competitors for shares of provincial/territorial funding (as opposed to being competitors in achieving high standards of performance). But the solution to one of the principal problems facing health care is to make the “silos” into a genuine system in which the several “players” are members of the same team, all concerned with using the budget allocated to them to provide patients and their families with a smooth continuity of high quality, compassionate care. A real system would not include incentives that encourage acute care hospitals to solve their financial problems by discharging patients too early to nursing homes, home care or to unpaid family caregivers or for family physicians to refer time-consuming patients to specialists or those seeking out-of-hours service to hospital emergency rooms. Integration of funding constitutes an important aspect of accountability. It ensures that the manager of that funding has responsibility for financing a broad range of health care services; it also ensures that efficient substitution decisions be made between and among different services. Although it cannot eliminate arguments over the adequacy over-all of the funding provided (no mere procedure is likely to do that), integration of funding forces such substitution decisions to be made at the only level where the information necessary to make good decisions is available – on the ground as close as possible to the people affected by them, providers and consumers alike. lxiii

We recommend:

THAT in planning and implementing devolution to subsidiary agencies of authority and responsibility for oversight of the management of health care every effort be made to ensure that both responsibility and the associated funding be transferred together as quickly and as completely as possible, the latter (funding) being transferred in a single
“envelope” and (in general) without “earmarks” i.e. designation of any proportion of that envelope for specific purposes.

6. Monitoring and Measuring Performance

It is insufficient simply to fix goals and objectives and facilitate their achievement by devolving funding for a broad range of services. Progress toward their attainment must be monitored. To do so requires productivity and outcome measures, products of the capacity to record, share, and manage health information. The capacity to manage information is a basic requirement of every successful enterprise. With respect to health care such capacity is sadly deficient in Ontario and elsewhere throughout Canada.\textsuperscript{lxii}

Although monitoring is vital, there is also the danger that the monitoring process will focus on those indicators that are easiest to measure.\textsuperscript{lxiii} A clear lesson to emerge from the experience with internal market reform in both the UK and New Zealand is that it is easy to focus on easily measured objectives such as increased turnover or reduced waiting lists and to ignore or “leave until later” the development of methods to measure more important but hard-to-measure indicators like, for example, the outcomes of hospital-patient or physician-patient interactions. To avoid having the system skewed towards that which can be measured easily it is vital that more abstract and broader measures of performance (such as people's satisfaction with the care health system or maintaining and improving the quality of services delivered) are developed and collected as important performance indicators.

Therefore, we recommend:

THAT the Ontario government work with other provinces, the National Health Council, and Canada Health Infoway on the development of sensitive measures of health care outcomes, of the quality of services (including patient satisfaction), and its accessibility (including waiting times), and

THAT the Ontario government develop financial and other incentives (such as public recognition) to engage RHAs and IHSs, together with the providers of health care, in the development and utilization of such measures.

7. Incentives for Performance
A key change involves shifting from what is primarily command and control, Ontario’s rules/regulation type of governance, to an incentive-based system that promotes more effective performance by those who govern and manage the system and those who provide its services.

It is important to ensure that managers, whether regional or central, have incentives to achieve the qualitative and quantitative goals and objectives that government sets. Very little attention has been given in any Canadian province to applying incentives to ensure that Regional or District Health Boards are responsive and accountable to the citizens they serve. But this is not a failing peculiar to Canada; most jurisdictions that have experimented with devolution have failed to harness adequately incentives to ensure good performance. The assumption seems to be that somehow inherently these new bodies will be able to cut through the morass of vested interests in health care and will always serve the public interest. For example, Thatcher’s internal market reforms in the UK were criticized for not providing penalties for purchasers that arranged "bad" contracts for the supply of health care services, yet those contracts denied patients care in the same way as did the alleged inefficiencies of the old command-and-control system. Similarly, the New Labour Reforms do not impose any penalty or sanction for Primary Care Groups that do not perform well, apart from firing their managers. In New Zealand, no incentives were built into contracts for managers of Regional Health Authorities (the purchasers), apart from the prospect of dismissal, a penalty more of a safety-valve mechanism and insufficiently nuanced to ensure good performance.

In the absence of incentives for RHAs and their managers, there is no engine to drive smart decision-making. In the public sector, the hope seems to have long been that the appointment of “good” people alone will be sufficient to serve the larger public interest. The appointment of good and skilled decision-makers is a necessary but not sufficient condition for decision-making that works to serve the public interest. Decision-makers need not only skills, comprehensive information, and necessary resources but they also need incentives to make decisions over time that strike the right balance between the needs and values of patients and between broadly-defined societal interest.

There are many ways of designing incentive-based systems and a myriad possible incentives themselves to ensure good decision-making on the part of those with devolved responsibility for governing and managing health care on a regional or community basis. Developing and putting those incentives in place is key to galvanizing and re-energizing our public health care system. It
is important to note, however, that despite well-crafted incentives, the ability of any central government to monitor a regional body’s performance may be limited by political factors. Thus, it is important to consider also the incentive RHAs have to be directly accountable to the people of the region they serve.

We recommend:

THAT the Ontario government depend primarily on incentives to ensure that RHAs, IHSs, and, through them, the providers of health care work to realize its vision and achieve the mission, together with the goals and objectives set for Ontario’s health care system.

THAT the financial incentives be a mixture of bonus and penalties. By bonus we mean rewards earned by RHAs and IHSs for performance that meets and exceeds the average as determined by measures of health outcomes, quality of care, accessibility of services, the cost effectiveness of their provision, and patient satisfaction. Penalties may range from financial penalties, to publication of reports of poor performance, through to dismissal. Other incentives could include public recognition in annual reports on the comparative performance of RHAs and IHSs throughout Ontario. The point of incentives is to drive a finite set of resources in the optimal manner, toward good performance and away from poor performance.

THAT RHAs and IHSs not be punished for carrying a reasonable margin of “surplus” from year-to-year and be rewarded for investing savings in future innovation. Any prudent business retains earnings to smooth out cycles and invest in change. Presently, hospitals are indirectly punished by reductions in their subsequent budget cycles if they do not spend at least all they receive each fiscal year from the government.

**Conclusion**

Devolution, in effect and in fact, inserts a new layer of decision-maker between the regional providers and consumers of health and health care services and the principal funder, the provincial government concerned. The logic of devolution\textsuperscript{lxvi} is based on the assumption that a
change in where power resides will have a beneficial impact on the accountability for and performance of the health care system.

If devolution is indeed an important part of the solution to filling the gaps/deficiencies we have identified in governance, management and accountability then one would expect to see Ontario falling behind, relatively, other provinces in Canada. The fact that this is not the case does not negate our thesis but rather illustrates three points. First, the benefits of devolution are not immediately apparent or measurable over the short term; the effects are long-term and systemic. Second, devolution is only part (albeit an important part) of a comprehensive solution required to reinvigorate publicly funded health care in Canada. No province has embraced a comprehensive set of reforms that harness incentives to achieve public sector goals. Other reforms, beside devolution of managerial responsibilities, required are: integrating funding for a range of services; monitoring/measuring performance; developing sensitive outcome and productivity measures; and shifting from what is primarily command and control (a rules/regulation type of governance) to an incentive-based system to promote effective performance both by those who govern and manage the system and those who provide its services. Finally, devolution has been implemented (or not implemented) in most provinces in Canada in a fashion that ensures that it will not fully succeed. The three interconnected factors hindering successful devolution in Canada are (1) despite the rhetoric, devolution of managerial responsibility has not in fact occurred; provincial ministries still closely manage decisions; (2) RHAs have little capacity to transfer funds from sector to sector because of line-by-line budgets negotiated or set by the Ministry of Health; and (3) fiscal responsibility for key sectors, like physician services, has not been transferred. Expecting devolution to succeed in these circumstances is like hoping Donovan Bailey will break the 100 metres world record in dancing slippers.

In Ontario today, after several decades of Medicare, it is obvious that, because it is the single biggest funder, the general public considers the provincial government of the day to be directly responsible for every problem in health care, imagined or real. Public opinion in this regard is highly conditioned by two major forces, the providers of health and health care services and the media. The Minister of Health and Long-Term Care and, through him or her, the government as a whole, is in the unenviable position of being held accountable for a health care “system” that does not really exist. Among the providers of health care services – hospitals, physicians, pharmacies, nursing homes, home care providers, dentists, etc. – none or at most very few would freely acknowledge that they are contributors to the collective work of a system much less individually
accountable to the Minister of Health and Long-Term Care for the quality and quantity of their performance. The Minister (and government of the day) is cast in the role of governance only with respect to providing the majority of funding (out of tax revenues) and as the recipient of blame when things go wrong (or not right) in the so-called system. It is an example of responsibility without authority. It is not effective. Nor is it sustainable. Something different must be done.

Devolution of power and authority over health care services to RHAs, IHSs or other bodies is not the holy grail of health reform. There is no single solution to the complex set of problems that have to be solved. But devolution to the subsidiary bodies we describe will resolve the problem of creating effective governance of Ontario’s (or any jurisdiction’s) health care ‘system’ and holds the promise of being a key element in reforms to bridge existing gaps in management and in accountability as well.

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10 In the health sector, McAuslan gives the example of senior consultants in the UK's National Health Service awarding themselves publicly-funded merit awards -- P. McAuslan, 'Public Law and Public Choice' (1988) 51(6) Mod. L. Rev. 681 at p. 689.

11 For example, the notion that politicians are only interested in expanding their own political empires does not rest well with the phenomenon in all industrialized countries where governments across the political spectrum have actively tried to either down-size or privatize public organizations. Clearly, ideas (or at least ideology) have some currency here.

12 G. Brennan and J. M. Buchanan, 'Is Public Choice Immoral? The Case For The 'Noble' Lie', (1988) 74 Va. L. R. 179 at pp. 187–8, argue that public choice theory becomes problematic when it is used in the positive sense as a predictive model of behaviour in political roles. They argue that the proper role of public choice theory should be in the normative sense of institutional reform, meaning improvements in the rules under which political processes operate.


Take, for example, deciding on one of the major cost-drivers in hospitals, the rate of pay of nurses. Most (but not all) hospitals participate in negotiating such rates through their agent, the Ontario Hospital Association. The decision to negotiate in this way is made by each hospital board which also ratifies formally application of the outcome to the nurses its hospital employs. But the parameters of the negotiation and its outcome are highly influenced if not determined by decisions made by the government through the Ministry of Health on the increment in funding to be provided to hospitals province-wide, year by year, independent of the relative cost of labour and of living in the communities affected.


For example, regional health authorities, organized for a geographically defined region may not be well suited for large cities in which competing integrated health systems may work better.


In the US, several studies have shown that large insurers are able to extract discounts from providers. See, for example, F. Sloan and E. Becker, “Cross-subsidies And Payment For Hospital Care” (1984), 8 Journal of Health Politics, Policy & Law 660. In those countries where government expenditures account for the great majority of total health expenditures, government has been able to use its monopsony purchasing power to control costs – see Health Care Study Group Report, “Understanding The Choices in Health Care Reform” (1994) 19:3 Journal of Health Politics, Policy & Law 499.

In the context of Aboriginal self-government where this has long been recognized as a problem.


Between 1989 and 1992, Quebec established the Regional Boards of Health and Social Services (Régies régionales de la santé et des services sociaux, or RRSSS’s).

Ontario has not introduced devolution of authority; the North-West Territory has 7 (moving to 8 in 2003) health and social services authorities (HSSA’s).

In February 2000, the province announced 2000 A New Century - Bold Plans for Health in Alberta, which outlined a six-point plan to improve the health system. This was followed in December 2001 by the Report of the Premier’s Advisory Council on Health, A Framework for Reform, and the government’s response released in January of 2002, Alberta: Health First: Building a Better Provincial Health Care System.


Catchment area figures for all provinces sourced from the Canadian Centre for Analysis of Regionalization and Health, online: Canadian Centre for Analysis of Regionalization and Health website <www.regionalization.org/ProvChart.html> (date accessed: 17 June 2003)

British Columbia, British Columbia Ministry of Health Services, New Directions for a Healthy British Columbia, (British Columbia: Queen’s Printer, 1993).

Conducted by the Minister-appointed Regionalization Assessment Team, this review led to a revision of the New Directions policy plan.

British Columbia Ministry of Health Services, Better Teamwork, Better Care, 1996.
52 health authorities were created comprising: 11 Regional Health Boards, 34 Community Health Councils and 7 Community Health Services Societies. The Ministry of Health Services later found that “this governance model contributed to patient confusion and a variety of care problems”. Those problems included difficulty accessing services in a timely manner, unacceptably long waits for some treatment, and uncoordinated care of inconsistent quality. British Columbia Ministry of Health Services, “Restructuring B.C.’s Health Authorities”, online: Ministry of Health Services website <http://www.healthservices.gov.bc.ca/socsec/restruct.html> (date accessed: 8 April 2003).

Vancouver Coastal Health Authority (VCHA); Vancouver Island Health Authority (VIHA); Fraser Health Authority (FHA); Interior Health Authority (IHA); and Northern Health Authority (NHA).

See the Canadian Centre for Analysis of Regionalization and Health, “About Regionalization in British Columbia” online: Canadian Centre for Analysis of Regionalization and Health <http://www.regionalization.org/BC.html> (date accessed 5 June 2003).


DHA’s are hospitals for the purpose of the Health Act, the Revenue Act, and for the application of the Sales Tax Act; per s. 82 of the Health Authorities Act (NS) 2000, c.6.


Alberta is currently trialling alternative payment plans such as partnerships between physicians and RHA’s for which the RHA’s are funded by the province; however, no province has given sole responsibility to an RHA for physician remuneration within a region. Most RHA’s have some sort of advisory role on physician payments, such as in Quebec.

BC has delegated authority for its Pharmacare plan to the Provincial Health Services Authority, which is really an arm of the Ministry as the PHSA is responsible for coordinating the other 5 RHA’s and all province-wide health services such as cancer care and transplants.

Alberta, Regional Health Authorities Act R.S.A. 2000, c. R-10, S. 9; the “RHA”.

Alberta, Regional Health Authorities Act R.S.A. 2000, c. R-10, per S. 5, the RHA shall promote and protect the health of the region’s population, assess the health needs of the region, determine priorities for health services and resource allocation, ensure reasonable access to quality health care, promote responsive to the community and support the integration of services in the region.

Regional Health Authorities Act R.S.A. 2000, c. R-10, per s. 6. The RHA may also delegate to the CHC any power or duty conferred or imposed on it by the RHA.

Alberta, Regional Health Authorities Act R.S.A. 2000, c. R-10, S. 9

Regional Health Authorities Act R.S.A. 2000, c. R-10, per S. 14. The annual report contains audited financial information, senior management and board remuneration, and any other performance information required by regulation (i.e. the Minister).

Health Authorities Act S.N.S. 2000, c. 6, per S. 10 (the “HAA”). Interestingly, neither the DHA nor any person employed or engaged by the DHA is to be regarded as an agent for the Crown (s. 9 of the HAA).

Health Authorities Act S.N.S. 2000, c. 6, S. 20(f).
Health Authorities Act S.N.S. 2000, c. 6, S. 21(2)(b).


Pursuant to section 5(1)(a)(v) of the British Columbia statute, the Health Authorities Act, R.S.B.C. 1996, c. 180.


British Columbia, Office of the Auditor General, 2003/2004 Report 1: A Review of Performance Agreements Between the Ministry of Health Services and the Health Authorities (British Columbia: Queen’s Printer, 2003). The AG is referring to his March 2002 report, Information Use by the Ministry of Health in Resource Allocation Decisions for the Regional Health Care System, which concluded that the ministry was allocating resources across the health care system without the benefit of essential cost and performance information.


The agreements lack a specific purpose so that the ministries and the RHA’s held different views as to what the agreements are trying to achieve. Clear descriptions are needed of: responsibilities; objectives; performance measures; reporting requirements; and incentives and consequences.

Wildowsky’s Law of Medical Money – there is never enough!


APPENDIX 1: EXAMPLE OF A PERFORMANCE AGREEMENT (BC)

PERFORMANCE AGREEMENT
between
THE MINISTRY OF HEALTH SERVICES
and
XXX HEALTH AUTHORITY
APRIL 1, 2002 TO MARCH 31, 2003

This is an agreement between the XXX Health Authority and the Ministry of Health Services, setting out our mutual understanding of the respective expectations and performance deliverables for the three fiscal years, 2002/03, 2003/04, and 2004/05. It will be updated and renewed annually for a new three-year period.

Given that:

➢ The government is committed to providing high quality patient-centred care, improved health and wellness for British Columbians and a sustainable, affordable public health system;
➢ The government is committed to substantial restructuring of the health care system, while maintaining the priority of patient needs;
➢ The government expects the health authority to continue to meet the requirements of the various legislation, regulation and policy, remaining in force at April 1, 2002, subject to amendments made from time to time by the Government of British Columbia;
➢ The government has established directions in A New Era for British Columbia and the Ministry of Health Services Service Plan;
➢ The government has provided guidance to the health authority through the letter of expectation to the Chair of the Board from the Minister of Health Services, dated December 12, 2001;
➢ The government will monitor programs, services, and performance indicators to ensure compliance with the above direction and guidance;
➢ The health authority will continue to provide a broad range of health care and health protection services such as those provided by its predecessor health authorities;
➢ The health authority will continue to provide comprehensive, accurate, and timely reporting (financial, statistical, program-related, and person-based), as required by the Ministries of Health.

The parties hereby specifically agree that:

The Ministry of Health Services, in conjunction with the Ministry of Health Planning, will:

1. Provide in writing, to the XXX Health Authority, details of operating and notional capital funding allocated for each fiscal year, no later than February 22, prior to the start of the fiscal year, and a three-year estimate of future funding levels.

2. Provide total Regional Health Sector operating funding for the 2002/03 fiscal year of xxx million (as per the April 25, 2002 Ministry of Health funding update letter), by electronic transfer to the health authority, in 26 bi-weekly amounts, together with a notional allocation of $xxx million for Capital funding, as shown in the 2002/03 allocation to health authorities, enclosed with this agreement. Funding allocations from other sources within the Ministries of Health will be communicated separately.

3. Provide to the health authority, within one month from receipt, an assessment of the health service redesign plan and budget management plan as submitted by the health authority. This assessment may include additional requirements of the health authority and will constitute an addition to this agreement as Schedule B.
The XXX Health Authority will:

1. Develop and deliver to the Ministry of Health Services by March 22, 2002, a three-year health service redesign plan and a corresponding budget management plan. The health service redesign plan must conform to existing health care policy and standards.

The budget management plan must be balanced over 2002/03 and 2003/04 in total, and balanced for 2004/05.

Manage and deliver programs and services for the fiscal year ended March 31, 2003, such that the operating results are equivalent to or better than those projected in the budget submission.

Additionally, the unrestricted net assets (including internally restricted funds) at the end of fiscal 2004/05 must be equal to or better than the unrestricted net assets (including internally restricted funds) as at March 31, 2001.

2. Take action to achieve the objectives set out in the Priority System Performance Improvements shown in Schedule A, collaborating where appropriate with the Ministries of Health and other health authorities.

3. Agree to perform the additional actions outlined by the Ministries of Health in the response to the health authority’s health service redesign plan and budget management plan shown in Schedule B.

The Board of the health authority will establish a performance based component of compensation for the Chief Executive Officer and may extend its provisions to other senior executives at its discretion.

In the event of significant changes in government policy which will seriously reduce the ability of the health authority to achieve the targets set out in this agreement, the parties to this agreement agree to renegotiate its terms to their mutual satisfaction.

Agreed to, on behalf of the XXX Health Authority, by:

Original Signed by: Chair of the Board
Original Signed by: Chief Executive Officer

Agreed to, on behalf of the Ministry of Health Services, by:

Original Signed by: Honourable Colin Hansen Minister of Health Services
Original Signed by: Penny Ballem Deputy Minister

SCHEDULE A

PRIORITY SYSTEM PERFORMANCE IMPROVEMENTS

1. Emergency Health Services:

Expected Performance

Within the process directed and supported by the Provincial Health Services Authority, collaborate with the Ministries of Health and other health authorities in developing guidelines to better manage demands on the emergency health services in the acute hospital system.
The process will include a review of literature and research as well as practices and performance in other jurisdictions.

Subject to the early initiation of the process by the Provincial Health Authority and with the cooperation of the physicians in the Northern Health Authority, the product by year will be as follows:

a) 2002/2003 will be a set of guidelines for best practices in the management of emergency health care, including reporting requirements, measures, and assessments of service coordination. These guidelines will be adopted by the health authorities.

b) 2003/2004 will be implementation of the recommended practices, including recording, reporting, and measurements.

c) 2004/2005 will be improvement of the performance of the emergency health services in the health authority, as measured by these best practices, reporting requirements, measures, and assessments of service coordination.

Measures may include an implemented flu season response plan, regular sample surveys of the movement of selected marker conditions through the emergency system, and a reduction in wait times and periods on diversion in the emergency departments.

The work will include representation from the B.C. Ambulance Service.

2. Surgical and Procedural Services

Expected Performance

Within the process directed and supported by the Provincial Health Services Authority, collaborate with the Ministries of Health and other health authorities in developing measures of the performance of surgical and procedural services in the province’s hospitals.

The process will include the establishment of measures of the performance of the system in response to emergency treatments and procedures and the development of principles for establishing priority for care for non-emergency conditions/cases.

Subject to the early initiation of the process by the Provincial Health Authority and with the cooperation of the physicians in the XXX Health Authority, the product by year will be as follows:

a) 2002/2003 will be:
   i. the development of measures of the response of the health care system to emergency surgical and procedural needs;
   ii. agreement on the principles to be used by health authorities in classifying cases as emergent or urgent/elective;
   iii. a plan to measure the appropriateness and outcomes of selected procedures (RESIO); and
   iv. adoption by the health authority of these principles and measurement procedures.

b) 2003/2004 will be the introduction of these principles and measurement procedures.

c) 2004/2005 will be demonstrated improvement of the performance of the surgical services.

3. Mental Health Services

Subject to the provision by the Ministry of Health Services of the capital required for construction of Riverview replacement facilities and the annual funding for the operation of these facilities being transferred
with the patient coming from Riverview; and the validation of mental health patient information data, expected performance will be as follows:

a) Increased use of needs-based and evidence-based best practices to achieve:
   i. Increase in early intervention capacity as evidenced by the decrease in average patient age at first contact with a physician or health service provider for serious mental illness;
   ii. Decrease, by 4 percent over three years, in the alternate level of care days spent by mental health and alcohol and drug clients in hospitals once the primary need for inpatient care has completed, specifically:
      Target 02/03 zero %
      Target 03/04 2 %
      Target 04/05 2 %
   iii. Improved continuity of care measured by the proportion of persons hospitalized for a mental health diagnosis who receive community or physician follow-up within 30 days of discharge.
      Target 02/03 3 %
      Target 03/04 3 %
      Target 04/05 3 %

b) Development of Riverview replacement units in selected locations—to be achieved over the 3 year period, specifically:
   Target 02/03 x units
   Target 03/04 x units
   Target 04/05 x units

4. Home and Community Care

Expected Performance

a) Full implementation of the new assessment tool for home care (MDS-HC) over the next three years.

b) Full implementation of the new assessment tool for residential care (MDS V2.0) over the next five years.

c) Increase the proportion of home and community care clients with high care needs (requiring care at the IC2 level or higher) living in their own home, or in non-institutional facilities.

This is indicated by the number of high care needs clients at home or non-institutional facilities as a percentage of high care needs clients in total.
   Target 02/03 2 % increase (e.g. from 45% to 47%)
   Target 03/04 5 % increase (e.g. from 47% to 52%)
   Target 04/05 5 % increase (e.g. from 52% to 57%)

Targets will need to be re-evaluated with the emergence of high needs young adults entering the healthcare system.

5. Public/Population Health

Expected Performance

a) Collaborate with all other health authorities and the Ministries of Health in the development of core prevention and protection programs, and in the review of literature and research of best practices and performance in other jurisdictions.
Participate in consultations which will begin in 2002/03 and will result in:

i. In 2002/03, the development of a list of prioritized core programs for protection and prevention;

ii. In 2003/04, the development of core program delivery expectations and performance measures; and

iii. In 2004/05, the incorporation of appropriate core programs into a new Public Health Act.

b) Implement the recommended core programs, including recording, reporting, and measurements in 2004/05.

c) In 2004/05 improve the performance of the core prevention and protection programs as measured by the indicators developed as above.

6. Support and Administrative Services

Expected Performance

a) Reduce the annual expenditures for Support and Administrative Services (excluding Information Systems), by the 2004/05 fiscal year, by at least 7 percent of these expenditures incurred for the fiscal year 2001/02.

Note: Annual or multi-year targets for individual authorities, for each priority program area, will be determined in negotiation with the Performance Management and Improvement Division.

SCHEDULE B
OUTSTANDING ISSUES

The Ministry of Health Services has approved the xxx Health Authority’s health services redesign and budget management plan with the understanding the following issues require ongoing discussion and subsequent action:

- Confirmation the proposed transition in acute services, in relation to other health sectors, will be implemented in a planned, integrated, and timely manner.
- Submission of a comprehensive transition plan, including the timetable and implementation strategies, for achieving the New Era commitments for home and community care.
- A clear articulation of the changes planned for mental health services, confirmation these changes complement the implementation of the British Columbia Mental Health Plan, and are integrated across the health sector.
- Confirmation that utilization management plans exist for the region.
- Delineation of the steps to be taken to strengthen primary care services in the region.
- Confirmation that maternity care delivery is consistent with the British Columbia Reproductive Care Program Report on the Findings of a Consensus Conference on Obstetrical Services in Rural or Remote Communities (February 2000).
- Confirmation of progress in the implementation of the health authority’s medical academic program.
- Submission by the health authority of an aboriginal health plan by September 3, 2002, and linkage of this plan to other health services.
- Provision of a revised budget management plan, by June 30, 2002, which reflects unrestricted net assets (including internally restricted funds) at the end of fiscal 2004/05 that are equal to or better than unrestricted net assets (including internally restricted funds) as at March 31, 2001.
- Provision of a three year calendarized implementation schedule which links initiatives in the health service redesign plan to the revised budget management plan by June 30, 2002.
- Provision of a combined program and financial risk mitigation and contingency plan by June 30, 2002.
- Submission of any outstanding capital asset funding details, including:
  the funding source for projects, which maybe proceeding (i.e. health authority restructure funding, CIP/equipment funding, health authority debt service/amortization).
  These projects are cited in Attachments D and E of the February 4, 2002, letter from the Ministry of Health Services.
- Project lists and individual project details as noted in Appendix 1 of the Health Service Redesign and Budget Management Plans instructions.