# Healthcare Governance Models in Canada

# A Provincial and Territorial Perspective

# National Summit April 2013

## Final Report

## November 2013

All presentations and background material prepared for this Summit are available at http://www.ipac.ca/e-store/NationalEvents

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## I. Introduction

Governance counts, especially in the complex field of health care. The IPAC National Summit, ***Governance Models That Work! Health Care Governance in Canada: Where Do We Go From Here?***, April, 2013, provided a rare opportunity for thought leaders, governors and executives to discuss healthcare system governance in Canada. With a deep understanding of the complex nature of the health care system and the increasing focus on quality, safety and systems integration, discussion centered on how the many actors within that system have to organize, set goals and provide oversight to make it all come together in terms of positive health outcomes. That is the heart of good governance. This report summarizes the discussions and outlines the key learnings of this Summit.

Participants came from across the country, providing and benefiting from a variety of perspectives. They included health authority board chairs, CEOs, practitioners, academics and consultants in the field. There was a strong focus on regional health authorities and their role in health care integration.

The Summit discussions drew on a background paper prepared by IPAC, in partnership with Fasken Martineau DuMoulin LLP and MNP LLP. The paper provided an overview of governance models in jurisdictions across Canada and a legislative review for each of the ten provinces, Yukon and the Northwest Territories.

The event provided a foundation for further discussion. We heard from delegates that continued dialogue and sharing of key learnings is vital to sustained effort.

Note: Throughout we will use quotations heard in plenary and break-out sessions. We will not be attributing these quotations as discussions were in confidence.

## II. The Situation Today: Profound Shifts Toward Quality and Accountability

Ontario Deputy Minister of Health Saäd Rafi, in opening the Summit, noted that the case for change is significant. Currently, in Ontario, 42% of spending goes to healthcare. With the rapid aging of the population, this could go to 70% - 80% within a decade. A move to put people and providers at the centre of the system is needed to slow these trends. In Ontario, the new HealthLinks initiative provides an example of taking an integrated approach and working with the most vulnerable groups across the primary care system, at a grass roots level, to get better outcomes.

Tom Bigda-Peyton, Managing Partner, Second Curve Systems, in his presentation on second curve systems, noted that Canada's healthcare system faces a myriad of challenges. With the advances in technology, medical science, increasing social and environmental complexity, the craft model is fraying, with increasing cost pressures, unacceptable error rates, lack of accountability and concern about access to care. In the second curve model, the healthcare system is based on a conscious, coordinated system, focused on quality of care and safety. Organizations begin to work as a system.

Effective governance becomes a key in overseeing a systematic approach. Daniel Cohen, International Medical Director, Datix Ltd., provided a number of examples of instances where lack of accountability and oversight resulted in poor quality of care and in some cases significant negative outcomes. Accountability and transparency are central to a high-performing system. Delegates agreed that these trends are increasingly evident. However, much remains to be done. For instance, provincial legislation governing health care, as noted in the study provided to the Summit, was only now evolving to the point at which quality was mandated as a primary standard and in which accountability is better laid down.

Donald Philippon, brought an international perspective to the healthcare discussion. He provided comparisons of the Canadian system to healthcare systems in six other Countries: England, Sweden, New Zealand, Australia, Netherlands and Ireland. These countries were selected for their ready comparability to the Canadian scene.

The research presented indicated that most healthcare outcomes are better in the comparator countries than in Canada with costs generally lower than in Canada. [i] (Details are available through the IPAC website). The main conclusion was that, while we are making progress in areas such as access to primary care and to specialists, we are lagging behind other countries.

The discussions identified a number of important themes:

- Inequities still plague the system,
- Cost pressures persist, most notably for the aging population,
- Service integration is moving, but slowly and inconsistently,
- The trend toward more and better information on performance is positive,
- Service innovation initiatives abound and need to be shared better, and
- Overall, the system is well funded, but the funding is not well distributed to maximum effect.

**Participant Comment**: *"We did not hear from anyone today that more dollars should be invested in healthcare."*

## III. Does Governance Structure Matter?

Delegates supported the concept that good governance of the health system is necessary. While it will not solve the major problems confronting the health system, it is necessary to create the conditions under which problems become solvable. A notable feature of the governance of health care is that insufficient attention has been paid to predictable and clear definitions of roles, authorities and funding, especially for regional health authorities. This has created needless ambiguities in the governance process. It was noted that provincial ministries often continue to operate in first curve modalities of control and do not vest adequate authority in the governance structures they create at regional level and hold them to account in a second curve way for quality and accountability.

Delegates agreed that there is no one ideal system. We heard from a number of delegates that there is too much focus on structural change. A change in governance structure is an easy way for governments to appear to be making change in the health system.

Don Phillipon noted that "Structural change sucks energy and resources out of system, creates uncertainties".[ii] There is a propensity to reorder and restructure, and this trend occurs worldwide. The problem is that governance structures take time to gain legitimacy. Restructuring takes the focus away from service delivery, and should only be considered when truly necessary. Legitimacy and acceptance of the governance structure is critical for system stability.

Our research confirmed that most healthcare governance systems in Canada have undergone significant and frequent change. They have faced frequent structural changes, and changing political environments. Provinces/Territories continue to review their governance structures, often without considering the sunk costs and the destabilization that change brings. Delegates noted this as a major concern.

Delegates in a number of jurisdictions also expressed concern that there are too many layers of governance (i.e. institutional, local and regional). It was suggested that layers of governance should be pared down where possible.

## IV. A National System

As a federation, Canada faces the challenge in the health care area of developing and implementing a national healthcare strategy due to the constitutional division of responsibilities. When considering international perspectives, Don Phillipon noted that unitary systems that define the scope of their healthcare system nationally (UK, Sweden, Netherlands and New Zealand) have less difficulty implementing changes to their systems. Federations, such as Australia and Canada have more difficulty. Also of note, Australia and Canada are on different paths at the moment. In Australia, the Commonwealth (Federal) Government role is increasing. We are not seeing this trend in Canada.

In the Canadian model, leadership is diffused. Constitutionally, the Provinces/Territories are responsible for health care. The Federal Government's spending power and the major funds transfer program have put it in a command role that it can use to direct or merely support the Provinces/Territories. Forging national responses becomes complex. Significant work has been done at the federal-provincial level to reach agreements in a number of key areas. Despite this work, delegates indicated that we do not currently have a true Canadian healthcare system, although as Jeffrey Simpson, author of ***Chronic Condition***, noted Canadians often define themselves by their healthcare system. As Canadians, we are governed by a series of healthcare systems, which are providing levels of care that are varying to some degree. As Canadians, If we want more commonality in service levels, and coverage of services, we need to consider looking at certain healthcare issues from a national perspective.

Delegates suggested that the federal role could be enhanced in a number of areas. Most agreed that Canada could benefit from a national healthcare strategy. While a national presence is important, delegates reiterated that it is also important to maintain provincial/territorial and regional responsibilities to meet the varied needs of population groups across the country. The national discussion needs to occur within the federated system.

## V. Government-Health Authority Relationship

**Participant Comment**: *"Community health boards have their finger on the pulse, they are the eyes and ears of the community"*

There was a consensus that some form of regional authority is important if effective governance of all health care resources in the region are to be integrated. The role of regional authorities is to link local health care providers to implement and deliver provincial policies.

There was also general consensus that some consolidation of authorities, as has occurred in a number of jurisdictions, was a good thing. There is a balance that needs to be struck between local involvement and the need to streamline governance structures. In Quebec for example, there are 17 regions, and there is a desire to bring it to 8. In Nova Scotia, as part of their political platforms, some parties promote reducing the number of authorities.

Delegates noted that single authority systems have advantages in terms of consistency, but they also have challenges. With a single authority, it may be more likely to see overlap with the role of the provincial health ministry.

**Participant Comment**: *"Administration and leadership need to be mindful of their influence. It is important to set policies and then – get out of the way of those implementing them."*

Regional models break down the Province/Territory into more manageable areas and also the number of services to be integrated. Local needs can be more readily isolated and responded to. However, for regional authorities to work well, clarity of powers is needed. RHAs/LHINs need to be able to follow through on the areas that they have responsibility for. In general, the provincial/territorial health ministry develops healthcare policy and strategic directions. Health authorities are responsible for operations and delivery. When Ministries of Health venture into operational matters, this can create issues for the health authorities.

Governance for regional authorities needs to be designed on a systemic as opposed to a piecemeal basis. It is important for RHAs/LHINs to have a defined scope of influence. Delegates indicated that regional authorities need to have the powers and funding to carry out their mandates. Above all they cannot be frequently overruled by the provincial/territorial government. This subverts the governance model.

Delegates felt that the relationship between the RHA/LHINs and the government needs active management. Mutual respect and collaboration are important. The balance between provincial/territorial-wide direction and local autonomy must tilt in favour of systems integration, stronger focus on primary care services, no-blind-sided governance leading inevitably to better accountability. Above all, the public need to understand who to hold accountable.

## VI. Stakeholder Engagement

Delegates sent a strong message regarding community involvement in health care governance. Community engagement is key to making healthcare systems work. Engagement needs to be integrated into the governance models at the regional level. For the health system to have legitimacy in the minds of the people it serves, the engagement of those served is critical. The more distant the decision-making process is, the less likely people are to buy into it, and the less likely it is to meet the needs of the people it is trying to serve. However, Summit participants pointed out the challenge of profile for regional authorities in the public eye. Often they do not have a strong public presence, overshadowed by the provincial health ministry or large hospitals. To engage, they must become more visible and better understood.

> **Participant Comment**: *"People need to feel that the healthcare system belongs to them – and that their voice is heard in the decision-making process."*

Delegates indicated that there is a gap in meaningful engagement at the moment in most jurisdictions. Real community involvement in decision-making is important, and is often lacking in planning processes.

It is also important to engage those working within the healthcare system. Health professionals must be part of the process as well for the system to have legitimacy. These stakeholders have unique perspectives to bring to the development of governance structures. There is a need to have the clinicians on the same page as the community.

Regional authorities must recognize that they need to develop and sustain relationships between sites and programs while still ensuring the unique nature of the regions is maintained. It is important to build on what is working in a region, and to recognize that every service cannot be provided in every area. The ultimate goal is to ensure that there is an integrated continuum of care, and that duplicity is removed from the system.

## VII. Good Governance for Regional Boards

Summit participants spent considerable time discussing the skills sets needed for good governance. In general, regional authorities need skills on the board that are similar to large public and private boards. Filling a board with the right skill mix and the people with time to focus on the work is a challenge. In too many instances, regional board directors are selected on the basis of representivity or geography and not enough on personal/professional skills. There needs to be a balance between selecting board members on the basis of needed skill sets versus local knowledge and connection to the local community.

Full board capacity is essential for effective governance. Summit participants noted the risks that arise when boards carry vacancies too long due to the appointment process - a process that is often out of their hands. There is a need to address the issue of board vacancies, in certain jurisdictions, by reducing the time that it is taking for governments to make appointments to regional boards.

Governments should consider whether compensation for board members would improve the quality of board appointees. The time commitments that a regional directorship represents can be significant, and for people to take up the challenge, compensation may be required.

## VIII. Managing the Fiscal Issue

Effective governance has to be built around the notion of fiscal restraint as a permanent reality. All jurisdictions are facing funding challenges and the sustainability of the healthcare system is an issue everywhere. Once again, there was a general view that this restraint and taking a systems view of governance goes hand in hand. Delegates noted that the health care discussion in Canada is changing. Those working within the healthcare system, policy makers and planners are all recognizing that more needs to be done with the funding we have. New and creative ways are needed to enhance the healthcare system without spending more money.

Delegates noted that there are a number of areas to consider:

- Funding models need to be reconsidered. For example *"dollars follow patients"* models should be considered.
- There should be more discretion and less formula-driven processes over allocation of dollars.
- Processes must be put in place permanently to force the system to continually look for efficiencies.
- Healthcare systems need performance measures that recognize people/institutions for exceeding their outcome goals, finding efficiencies.

Effective governance can contribute here by:

- Focusing on costs and continuous cost review,
- Pushing for performance metrics with effective links to costs,
- Sharing and distributing information on ways to reduce overall system costs.

## IX. Key Learnings: The Take-Aways

**1.** Effective governance structures are built on philosophy and culture. Jurisdictions should approach the development of governance models in an outcome-driven fashion.

**2.** Once a Province/Territory has a model, stay with it. Slow down structural change – let the systems stabilize.

**3.** Do not use governance as a scapegoat for system underperformance.

4. Canada needs to achieve consensus on the scope and expectations for the healthcare system for all Canadians. This remains unresolved.

**5.** A form of regional authority or regional involvement in healthcare is the most beneficial governance model.

**6.** We cannot have accountability let alone systems change without authority and resources. To be effective, regional health care systems must have the authority to carry out their mandates.

**7.** Governance systems must avoid duplication and clearly separate roles among levels of government. Too many layers of governance do not promote efficiency.

**8.** Meaningful community engagement is key. Strategies for engagement are needed at the local level. People need to be brought on side. They need to see their concerns addressed, and their interests met. Community engagement needs to be built into governance models.

**9.** We need enhanced partnerships between ministries of health and health authorities. Time and effort is needed to build trust and relationships, and to create an environment of mutual respect.

**10.** Engage citizens, patients, providers, community services in a deep conversation on what change we need and how fiscal discipline is an essential component of any system going forward.

**11.** The healthcare conversation is changing – the focus is now on solutions that don't involve more money. Governance models need to facilitate this move.

**12.** It is important to recognize that political influences will always be present and to create systems that can operate, at least to a significant degree, in that reality.

## X. Next Steps – Going Forward

This document informs the conversation on healthcare governance models going forward. Participants at the Summit felt that it is worth deepening the discussion.

Further actions could include development of a survey to reach a broader audience. Regular monitoring and tracking of this issue could add significant value to the regional, provincial and national discussions on healthcare.

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[i] Per capita expenditure in Australia (2009 figures or latest) is $3,445, in the UK $3487, Sweden $3,722 and New Zealand $2,983. Per capita costs in Canada are $4,363. Only the Netherlands is higher at $4,914.

[ii] IBID, Presentation by: Donald J. Philippon, PhD, FCCHL