

**COLLABORATIVE SYSTEM GOVERNANCE OF ONTARIO'S
LHIN-BASED HEALTHCARE SYSTEM**

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DISCLAIMER

This work was commissioned by the HRTIMP with a view to advancing discussion about the dimensions of a practical strategy to enable the 'collaborative governance' of Ontario's integrated healthcare system involving the Ministry of Health and Long Term Care, the Local Health Integration Networks and Ontario's many health service providers.

The analysis, opinions and recommendations contained in the paper are those of the authors and do not represent the official position of the Ministry of Health and Long Term Care.

For forms of government let fools contest;
 Whate'er is best administer'd is best:
For modes of faith let graceless zealots fight;
His can't be wrong whose life is in the fight.

Alexander Pope, Essay on Man, 1736

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1 Summary of Findings

This report presents a practical strategy to enable 'collaborative governance' of Ontario's integrated healthcare system, involving the Ministry of Health and Long Term Care, the Local Health Integration Networks and Health Service Providers. The primary focus of the proposed strategy is on a comprehensive, consistent, practical approach to achieve effective collaborative governance in these dimensions:

- Within each of Ontario's 14 LHINs (including the governing bodies of the LHIN, Community Care Access Centre [CCAC], hospitals, homecare agencies, community health centres, community mental health organisations, hospices; and other providers),
- across LHINs, and
- between LHINs and MOHLTC.

The paper defines collaborative governance, and proposes how it can be enabled in Ontario. Draft guidance on good collaborative governance practice is developed. There is no incompatibility between provider autonomy and independent governance, and high levels of system guidance and governance. Collaborative governance in such an environment will provide a more robust and flexible approach than greater provider consolidation would yield.

1.1 Areas for Action

No new formal institutional arrangements for collaborative governance are needed, whether in the form of further or additional committees or council structures, as this would only serve to further cloud accountability.

Priority attention is needed on the inter-LHIN agenda of how LHINs share and collaborate around common goals. Getting the inter-LHIN agenda right will permit the MOHLTC to delegate greater responsibility to LHINs for programmes of province-wide scope.

Providers with multiple-LHIN relationships, such as the academic health centres, will experience particular governance challenges for defining their relationships with multiple LHINs.

There is a potential challenge for LHINs having SAAs with a large number of relatively small providers, raising the question whether networks of providers need to establish a particular governance and service relationship with their corresponding LHIN.

The governance responsibilities of LHINs for their statutory duties, including the constitution of their Boards, should not be shared with providers, and importantly, LHINs should not have provider representatives on their boards, as this would be a conflict of interest.

A framework of core dimensions of collaborative governance is proposed to clarify and define roles and responsibilities of those involved in the health system. Specific governance guidelines for LHINs and providers are proposed.

1.2 Lessons for Enhancing Collaborative Governance

1.2.1 Lesson 1: Targets matter.

Horizontal and vertical decentralisation reform of decision-making is widespread in Europe and designed to ensure that discussions between stakeholders take place at the local rather than national level. Ontario can learn much from this.

Core components for LHIN/Ministry strategic coordination are:

- targeting and objectives at the provincial level applicable to all system actors,
- consistent performance measures across LHINs (to measure LHIN organisational performance, and to measure outcome attainment),
- a mechanism for linking the funding to the targets to enable LHINs to calibrate resourcing with provider attainment of outcomes.

This means that a performance framework, including metrics, quality indicators, standards and outcomes is important.

1.2.2 Lesson 2: Not everything is about decentralisation or regionalisation.

The Ministry is the guarantor of social values and choices. In that role, therefore, there may be some health service areas which require province-level coordination or which may require an all-LHIN approach to service development and funding.

Regardless, the MOHLTC is the stakeholder on behalf of the public generally best able to express how varying local social expectations link together within a common (provincial) framework. The provincial health strategy is a key tool for achieving this and there may be lessons from jurisdictions, which codify health targets in law.

This means that the MOHLTC may find it helpful for the achievement of the provincial health strategy's goals to review existing regulatory frameworks, to help LHINs and providers do their work better.

1.3 Clarifying the Roles of System Actors

- LHINs have final responsibility and accountability for negotiating outcomes in SAAs
- Service providers must respect LHIN decision-making responsibility and authority
- Ministry of Health must respect the devolved responsibility of LHINs for the provincial health strategy and ensure that the strategy is communicated and measured appropriately.

1.4 Learning from Others

By and large, Canadian and US experience is not helpful; in particular, Ontario's approach departs from the regionalisation approach of the other provinces by distinguishing the role of the LHIN from the role of provider.

- US approaches lack a focus on system planning.

- Regionalisation in other provinces has been at the expense of provider autonomy.
- European approaches are more relevant, sharing core social priorities, formal methods, and institutional arrangements and show the compatibility of provider autonomy and governance with system governance arrangements.

The Madrid Framework, has been developed in Europe. It comprises a number of 'dimensions' for health policy and governance. This approach is of relevance to Ontario, and a comparable model should be developed to guide development of collaborative and system governance to achieve:

- strategic alignment, with a systems-based approach to governance,
- institutional role clarification, in particular distinguishing between bodies responsible for system planning and payment, from bodies responsible for service delivery,
- devolution, decentralisation, redistribution of authority, etc., taking account of the interests, responsibilities and accountability arrangements of different orders of government, and how the different orders articulate their priorities, and with the roles of empowered health system actors.

1.5 Challenges for Ontario

Interviews with some key leaders in the Ontario health system reveal a high degree of consistency in the insights offered. All are concerned with:

- a continuing high level of uncertainty about what the ultimate 'real' role and responsibilities of the various players in the LHIN system will be in important areas, including governance;
- lack of clear communication within the healthcare system and to the public in this regard; and
- insufficient operational progress by the LHINs.

We observe that, in this vacuum, some legacy associations of healthcare service providers may have "collaborative governance" on their agendas as a way to continue with traditional untransformed patterns of service delivery. Diluting the governance responsibilities of the LHINs through greater apparent collective decision-making will only serve to undermine the objectives that the province's health strategy. This cannot be encouraged and in fact, there needs to be clear, direct, early communication with service providers to advance the LHIN-based transformation of the healthcare system.

1.6 Resourcing LHINs

It should be determined if LHINs need additional financial and human resources, provided in an accelerated time-frame over the next 12 months and certainly no later than the 2007/8 planning cycle, to undertake the necessary planning and development of integration priorities:

- Capabilities to address the cross-LHIN and system-wide priorities (including e-health and networking), as robust performance of the LHINs will permit the MOHLTC to delegate additional responsibility to LHINs for services that are province-wide,

- LHINs need access to consistent and high quality information particular to share information to build inter-LHIN capabilities and compare provider performance. LHINs will need to establish their own understanding of provider performance and priorities including service costs using independent sources.
- LHINs need to establish an independent relationship (separately from the MOHLTC and providers) with the public in their catchment areas.

1.7 Emerging Governance Priorities

This report has developed a framework for collaboration that requires considerable strategic alignment between LHINs and provincial health strategy. Emerging challenges for the MOHLTC within the governance framework are:

- ensuring consistency in performance and strategic focus amongst the LHINs
- ensuring cross-LHIN-boundary patient flows do not conflict with the plan to improve local patient access and reduce waiting.

The meaning of collaborative governance itself will evolve as the LHINs evolve:

- The role of collaborative planning between LHINs and providers where significant cross-boundary flow of patients exists will raise issues for how individual LHINs view available capacity, and therefore with what organisations are they collaborating and for what purpose; there are undoubtedly financial planning consequences here, too.
- Does the provincial health strategy provide the framework for all provincial health funding (or just the funding that flows to LHINs)? This determines in part the scope of the capacity planning by LHINs, and therefore with whom they collaborate, but also the extent to which integration opportunities can be explored for whole- or partial-system impact.

1.8 Summary of Advice

1. Health system actors must have the degree of autonomy necessary for them to do what is called on them to do including operational responsibility for LHINs in establishing their Board to provide leadership, providers to manage and govern themselves, MOHLTC to sponsor and oversee the system and protect social equity, and lead on policy.
2. The LHINs have final decision-making on the content, priorities and actions comprising the local health strategy.
3. LHINs and Provider Boards should not pursue any cross-appointments of membership.
4. Providers should reprioritise their strategic, operational and board activities toward the LHINs; there is no need for providers to have a Ministry or Ministerial relationship around their own strategic objectives.
5. The MOHLTC and the LHINs should determine at the earliest what governance relationship for strategic planning purposes should apply between LHINs and excluded service providers.

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6. The MOHLTC should coordinate policy implementation with the LHINs collectively to ensure that differences do not create weaknesses that undermine provider commitment to collaborative governance with local LHINs when their institutional interests are not prioritised by their LHIN.
7. The network of potential relationships is complex, and all partners will need to acknowledge this complexity as central to building good relationships and implementing the provincial health strategy.
8. There is considerable synergy between the governance approach in Ontario and the Madrid Framework, such that further work is appropriate to develop a comparable provincial approach.
9. The MOHLTC may wish to consider establishing a 'governance information system' [GIS] to enhance current initiatives concerned with web-enabled health system databases and communication.
10. The MOHLTC, the LHINs will need to assess what is the most appropriate way of informing the public about the integration of the health system and its performance.

2 Background

This report presents a practical strategy to enable 'collaborative governance' of Ontario's integrated healthcare system, involving the Ministry of Health and Long Term Care [Ministry] and the Local Health Integration Networks [LHINs].

The primary focus of the strategy is on a comprehensive, consistent, practical approach to achieve effective collaborative governance in these dimensions:

- Within each of Ontario's 14 LHINs (including the governing bodies of the LHIN, Community Care Access Centre [CCAC], hospitals, homecare agencies, community health centres, community mental health organisations, hospices; and other providers)
- Across LHINs; and
- Between LHINs and Ministry.

Led by the Health Results Team [HRT] of the Ontario Ministry of Health and Long Term Care [MOHLTC], the fundamental transformation of healthcare in Ontario is well advanced. It is the premise of this report's strategy that for this transformation to be fully effective, it is essential at an early stage:

- to reframe the understanding and practice of governance across Ontario's LHIN system to include a demarcation, understanding and communication of relative governance roles and responsibilities; and
- to identify and implement effective collaboration and accountability arrangements between and among the MOHLTC, the LHINs and community healthcare providers, including CCACs.

Since the founding of Medicare in Canada, Ontario's healthcare system has evolved with profound respect for the establishing values that define our healthcare ideals and objectives. The governance challenge, therefore, in a transforming system is to protect the values while unleashing the forces of transformation. In Ontario, the two new forces for change are the LHINs and the multi-year provincial health strategy. The legislative base for both is the *Local Health System Integration Act, 2006*, and that frames the governance arrangements that are proposed in this report.

To implement the province's transformative healthcare strategy will require creative, realistic solutions to problems understood within a 'system-based' approach to healthcare design, planning and delivery. This requires shared understanding of health strategy and policy objectives with a focus on implementation and outcomes. This will be manifested through governance arrangements, to create integration networks, new collaborative forms of service delivery and transformative change.

Importantly, and in contrast to practice elsewhere in Canada, Ontario has chosen to maintain the governance autonomy of individual provider institutions. International experience supports this position by the province and shows that provider autonomy is fully compatible with high levels of system governance, and indeed in the jurisdictions reviewed is seen as the preferred approach to maintain an environment of innovation and responsiveness to change. [World Bank, *Innovations in*

Service Delivery, 2003]. It lies in the clarification of system goals through an outcome-focused health strategy supported by performance metrics and appropriate funding arrangements that is the direction of system reform internationally, yielding more robust capabilities than increasing centralisation and consolidation. Provider flexibility within a system governed in this way is also seen as being more adaptable and responsive to direction toward improvement in health outcomes.

What needs to be done will, therefore, go beyond what any one partner could achieve. Such an approach necessarily involves:

- Shared vision and goals,
- Shared planning,
- Transparent, consultative decision-making,
- Shared risks, and
- A more open and responsive organisational and service delivery culture

2.1 Priority Questions for this Report

This report looks at collaborative governance through the lens of these questions:

- What is the experience of others? What are the lessons to be learned from, other leading Canadian and international jurisdictions with respect to collaborative governance of a regional healthcare system?
- What, if any, are the implications of the principles and practices of collaborative governance in each LHIN and across the LHIN system in terms of the governance relationship between the LHINs and the Ministry/ government?
- What is collaborative governance? What are its key principles, elements, attributes, benefits and challenges?
- How best can the framework of collaborative governance practically be adapted for and applied to Ontario LHINs? How can such a framework take account of the different mandates, local circumstances, responsibilities and accountabilities of the partner organisations and their varying levels of awareness, information, readiness and resources, including consideration of what explicit governance recruitment and development strategy should be developed and applied across each LHIN to facilitate collaborative governance and accountability? What, if any, are the implications of the principles and practices of collaborative governance in the LHINs in terms of the horizontal/ collaborative governance across the 14 LHINs (i.e. equity, cost effectiveness, efficiency, best practices, consistency and flexibility)?
- What explicit information management strategy should be developed and applied? How will this work within the LHINs to facilitate effective governance and accountability? How can the research, analysis, reports, templates and tools of the HRT IMP be of value in supporting the development and implementation of consistent, cost-effective collaborative governance in and across LHINs?

2.2 Methodology

The consulting approach was based on an inter-jurisdictional review complemented by targeted consultations with a small group of key valued informants, involving:

- A careful look at experience in other jurisdictions/ situations.
- Focused and sensitive discussions with selected key senior players in Ontario's healthcare system.

Research focused on:

- Canadian, American and European experience.
- Informal, off-the-record, meetings with some senior thought leaders in the Ontario health care "system".
- An excellent discussion with a senior legal advisor to the HRT on the legal implementation of the LHIN policy.

3 Detailed Findings

3.1 The nature of collaborative governance

Governance, as a concept, has many meanings, but is most often associated with such factors as institution building, capacity building, participation and accountability. It is also about the nature of the interaction between formal institutions, how policies are implemented and decisions made concerning public life.

Collaboration becomes the style of inter-institutional conduct. Governance is often meant to mean 'good governance' but this raises a problem of what to do in instances of 'bad governance' – what to do about it, how to identify it. Therefore, criteria to define accountability for good collaborative governance become important.

Governance arrangements have been associated with 'hyperbureaucratisation' – centralisation, excessive processes of consultation, proliferation of committees and other rigidities -- leading to organisational inertia. organisations excluded from collaborative arrangements have often created preconditions for their involvement that they will only be involved in 'good' governance arrangements, but failure to clarify what this might mean has led to inaction and policy failure. [*Government to Governance*, 2003 Hague Joint Conference on Contemporary Issues of International Law. TMC Asser Press, The Hague, 2004]

Therefore, the very real possibility of 'bad governance' must be taken into account in developing a system of collaborative governance, in particular to avoid 'non-collaborative' governance, that is, proforma participation without real collaborative intent. [Anil Hira, David Huxtable, Alexandre Leger, *Deregulation and Participation: An international survey of participation in electricity regulation*, *Governance* 18(2005):53] If such were to happen, the MOHLTC would find itself in a position of needing to intervene; therefore, conditioning the LHIN/Ministry/Provider system toward appropriate governance and collaboration conduct becomes important.

3.2 How do other health systems achieve collaboration to meet their objectives?

What other health systems are doing is instructive, and European health reforms are focused on concerns familiar to Ontario, offering important comparative learning.

Health system changes across Europe engage a variety of different forms of decentralisation, where local autonomy is increased, power being transferred from or devolved from government. This can take include deconcentration, devolution, delegation, or privatisation on the provider side where the providers are publicly owned.

There is also corresponding increasing demand-side competency by government in:

- planning and system design
- development of incentives
- regulations to encourage supply-side reform, through improved contracting, and

- performance metrics, setting outcome targets.

In Germany, health care is the responsibility of the Länder, and like Austria, health targets are set federally. Länder set their own health policy objectives as they have responsibility for the implementation of the health system itself. The federal level determines and defines various common aspects to ensure universality across Germany, and these are codified in federal law.

Italy sets objectives and targets nationally on a 3-year rolling basis in the National Health Plan, but these objectives are defined through associated actions and become integral to regional/local health plans. A key objective of the Italian reform of delegating greater local accountability has been to remove political influence from health care decision-making processes. Regional payers pay for services through these targeted plans that are required for federal funds to transfer to the regional level.

Each of these countries needs to reconcile federal/national health targets and plans with local or regional implementation. The mechanism in Italy is through performance measurement and financial allocations, a practice common to other countries. A key concern in countries with this approach is the real difficulty reconciling targets with local plans and monitoring what is done, as there is considerable diversity of local methods. This is clearly a top priority in the English NHS, where it has moved aggressively to define hospital activity in the service level agreements that hospitals hold with the Primary Care Trust to receive payment.

More generally, a substantial number of European countries are moving away from global hospital budgets to activity-based provider payment systems; Switzerland, Netherlands, Belgium, France are examples where legislation is proposed.

In Finland, Netherlands, Spain, and Sweden, the state sets the principles that guide local provision -- including regulations, quality standards, social insurance rates and benefits -- and importantly, permit a mixed economy of providers (public and private providers). In Spain, the 17 autonomous regions have responsibility, within these standards. Belgium sets country level objectives that are implemented regionally, but constitutional reform has produced a complex multiplicity of levels that make involvement in health policy making planning very difficult given the constitutional divide based on language. This is a particularly good example where the failure to define roles of participating actors has created a complex planning environment.

All the European countries referred to above set the standards in law in some form. This approach to system governance contrasts with the UK which does not set these standards in law, but builds them into the operation of the largely monopoly NHS system, at the country level (i.e. England, Wales, Scotland and Northern Ireland).

Codification of health system targets across Europe reflects more generally the legal status of payers and providers and how these countries use legal codes to govern the actions of mandated bodies.

Interest in creating separate bodies to undertake health care purchasing continues; Austria is introducing purchasing organisations to purchase services to predefined standards of quality and price. This illustrates the next generation of the purchaser/provider split, from simply a quasi-market mechanism, to an advanced purchasing model based on standards of quality, reference pricing, and activity-based contracts. There is the consequential loss of autonomy of social insurance sickness funds.

The British government has had to undertake a considerable regulatory realignment to get the various system components to work together; other European jurisdictions are gradually working through similar reviews. England's Department of Health retains central responsibility for system financing, defining system objectives and key strategies, with local purchasers deciding local (but centrally approved) plans and priorities. The English reforms are of considerable interest across Europe because of the strong integration, linking to public health, social care etc. What the English NHS has learned is the need to keep a sharp focus on the regulatory environment, which applies nationally, with common standards for quality and performance measurement, to guide local planning and implementation. It is a system designed to achieve health outcomes but it is also a system in evolution.

Our findings point to collaborative governance as deriving potentially considerable benefit from the removal of barriers that may create distortions between national strategy and local implementation. The risk is that collaborative governance could function well only with marginal issues, as really important and core issues will lack the necessary support in terms of quality, outcomes or performance standards, strategic alignment and policy prioritisation, which could make issues become contentious rather than collaborative. The effect is to push responsibility for problem solving to another level of government that may be ill-equipped or lack the desire to intervene locally.

The more complex the system in terms of decentralisation, the more complicated it is to reconcile the federal (or provincial)/local systems. Overlaps in role create a coordination problem, which requires resolution at a higher or other level of responsibility, especially if constitutionally-protected actions are involved. What is apparent in the decentralised regimes that do not codify their standards is that planning is more recursive and iterates over issues, so institutions must be more consultative more often; it is not clear which is better as they represent different levels of priority setting and consultation, and may reflect the preferences of the political and social culture.

Lessons for Ontario on Collaborative Governance	
Governance Feature	Lesson for Ontario
Governance is focused on achieving certain ends or goals; it has purpose and with purpose comes the basis for collaboration.	The purpose for collaborative governance will come from the provincial health strategy.
Clearly defined roles and demarcations of responsibility and respect for those boundaries enables better accountability and clarifies authority to decide. Respect for legal accountabilities and limits is essential.	Role definitions of LHINs, Providers, and the Ministry are required.
A way to reconcile differences of approach, priority and risk with methods of implementation is necessary to ensure that variations in practice are not seen as poor governance.	Common, system-wide outcomes ensure coherence, despite variance in local methods deployed by LHINs and their providers.
Targets with performance measurements that are agreed (and set at the highest level of jurisdiction) are critical in aligning actions, but also in establishing common national (provincial) benchmarks, and underpinning the basis for payment systems. This last point is becoming important as health care systems move toward funding activity rather than global block budgets.	<p>Performance measures are an important focus for informing collaborative discussions on system, LHIN and provider performance, and coalescing agreement on actions for failing areas in particular.</p> <ul style="list-style-type: none"> • Provincially agreed standards for quality, health outcomes, targets, and measurement; • Locally agreed capacity designed to achieve these standards; • Flexibility to design evidence-based service reconfiguration to achieve integration.
Appropriate organisational behaviours of transparency and openness in decision-making, and a bias toward equity and free expression of public interests need to be reinforced through the rules of conduct of boards.	Board rules of conduct and appointment methods for LHINs, and Providers identify equity and transparency in decision-making, public stewardship and leadership.

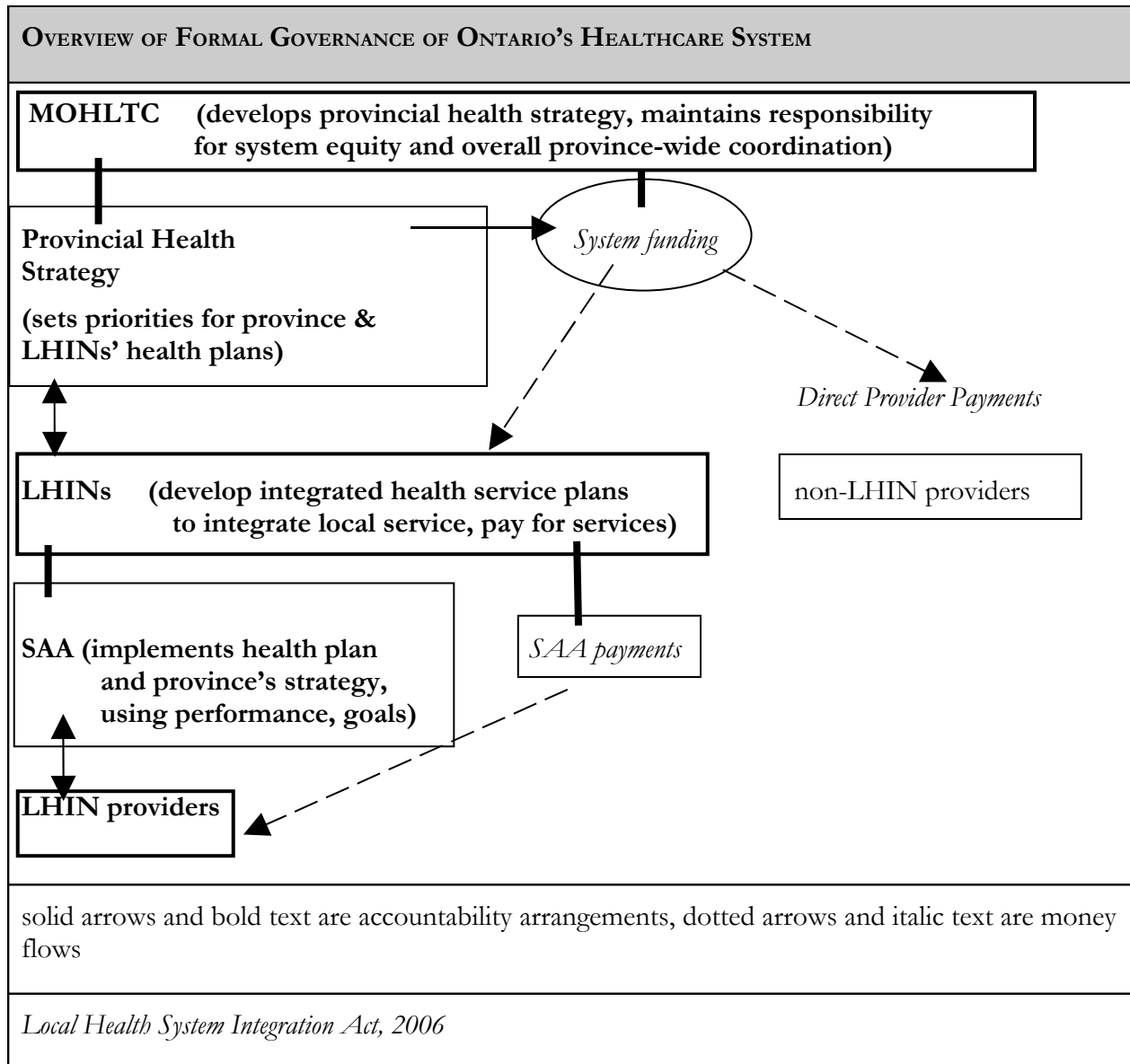
3.3 Formal governance in Ontario

It is clear from the international review that ensuring that the different system actors operate appropriately within their legally defined frameworks is also important to ensuring that the intentions of policymakers can be realised. In countries with civil codes, such as France, mandates of health service providers are explicit and codified. In countries where the voluntary tradition dominated in law, (common law systems), relationships are based on a shared perspective of the public good. However, in the latter, greater concern for system accountability, performance, and the demands of public auditing of funds, has increased the statutory requirements of providers. In England, relationships between providers and the NHS purchasers are characterised by legally defined duties to collaborate, for instance.

The LHIN legislation in Ontario lays out a variety of new relationships between system actors, and further defines specific roles. It is in these new roles and responsibilities that the nature of collaborative governance must be embedded to ensure the policy intent is implemented by the mandated actors. There is delegation of many MOHLTC areas of authority, in particular responsibility to oversee the strategic plan for integration for each LHIN's catchment area.

The MOHLTC has overall responsibility to ensure that there is a funded and functioning health system, with a new responsibility to develop a provincial health strategy [§14 of the Act]. This provides the evidence-base on population health and priorities to inform actions by LHINs. LHINs three accountabilities are to plan, fund and integrate [§5 of the Act] the local health system, in a consultative manner. Providers retain their autonomy and governance structures, but will become accountable to LHINs through SAAs for delivery of services. All must collaborate to achieve the province's strategic direction.

The diagram below maps out the formal structure of governance structure identifying key governance relationships between key actors: MOHLTC, LHINs, and Health Service Providers (those within the LHIN framework). The diagram identifies non-LHIN providers (ambulance, public health, physicians' services) that comprise a separate funding stream in the provincial health budget.



3.4 Collaboration and Good Governance

Based on formal relationships, LHINs and providers need a shared view of what the capacity of the local health system is, and what its capabilities are for integration.

This is seen as requiring at least the following factors:

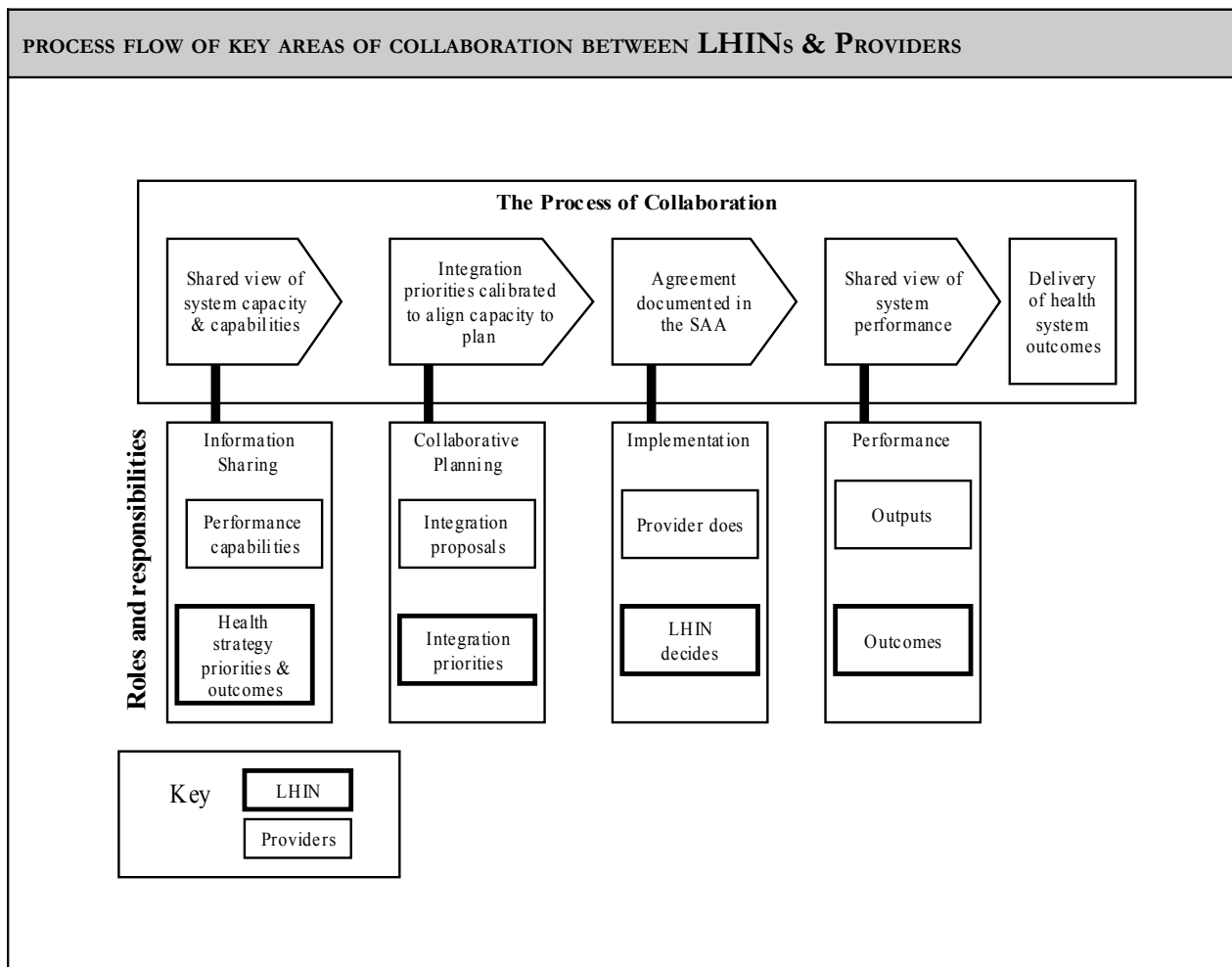
- define and clarify roles;
- address system actor autonomy;
- contemplate the inter-LHIN agenda, and multiple provider agenda;
- highlight equity, quality, and service accessibility outcome; and
- provide context and clarification relative to the current healthcare system.

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The purpose of the LHINs and providers to focus on collaboratively delivering the health strategy defines their common purpose within their differing roles.

The LHIN decides what service configurations are appropriate in negotiation with the providers, and documents this agreement in an SAA. The delivery of SAA outputs comprises provider performance, while achieving the desired outcomes of the SAA defines the LHIN's performance. Together, LHINs and providers have a shared view of system performance. The process then iterates in the next planning cycle, with new information on performance, capacity and outcomes. Focusing here ensures that strategy is the focus of collaboration, and helps to avoid provider-capture of system priorities.

The diagram below details the “collaboration process flow”, identifying the three areas where collaboration is necessary.



Accordingly, the relationships and the rationale for collaboration focus on alignment of institutional purpose around the provincial health strategy. The delivery of health outputs by providers is targeted toward meeting health outcomes for LHINs. It may be that in the currency of the LHINs output specifications are worded in terms of outcomes, rather than work volume.

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The SAA represents the most obvious evidence of collaboration as it documents agreement between LHINs and Providers and charts an agreed approach to assessing achievement of health outcomes for both. All collaboration, however, is focused on the health strategy and its requirements. This may prove challenging when dealing with substantial legacy capacity that may under-specify the desired outcomes, and clearly collaboration around differences of opinion here will be important. This can be summarised as follows:

ALIGNMENT OF PURPOSE, DECISION-MAKING AND PRIORITY-SETTING		
Strategy Formulation	Collaboration Arrangements	Delivery and Outcomes
<p>The primary method for communication of system priorities and outcomes from the Ministry to LHINs is the provincial strategy</p> <p>Consultation on the provincial strategy is with the general population of the province by the MOHLTC.</p> <p>Each LHIN will develop a corresponding strategy (LHIN Health Plan) for its catchment area.</p> <p>Outcomes (e.g. integration) will sit within SAAs</p> <ul style="list-style-type: none"> • SAAs can be as many and as few as LHINs require to operationalise strategy. <p>LHINs may focus on providers and/or services in scoping the focus of an SAA.</p>	<p>L+P collaborate to operationalise the LHIN and provincial strategy</p> <p>L+P collaborate to identify gaps, forward planning, risk assessment and threats to the strategy as operationalised.</p> <p>L sets priorities arrived at collaboratively with P that define the outcomes of the strategy</p> <p>L <i>decides</i> the priorities, the strategy and its outcomes and the implementation plan</p> <p>P responsible for risk management and ability to deliver to the strategy in the contract</p> <p>L responsible for outcome risk measured against the strategy and for assessing provider performance against the SAA.</p>	
<p>LHINs may need to establish inter-LHIN strategies to operationalise shared priorities with common providers or to operationalise provincial outcomes that exceed the scope of the LHIN (such as a provincial-level service or resource)</p>	<p>L collaborate with other L in order to pursue identified shared priorities with appropriate implications for P</p>	<p>Inter-LHIN <i>agreement</i> for provincial service delivery outcomes. Will there be Multi-LHIN SAA?</p>
<p>KEY: L: individual LHIN; P: Provider; SAA: Service Accountability Agreement</p>		

Further analysis of collaboration yields a matrix where agreements are needed. The matrix highlights

the need for agreement around the ability of providers and LHINs to agree how best to match provider performance to LHIN priorities.

DEFINING THE OUTCOMES OF JOINT DECISION-MAKING BASED ON A SHARED VIEW OF ABILITY TO DELIVERY OUTCOMES (PERFORMANCE): EXAMPLE			
		LHIN Strategic & Integration Priorities	
		Priority [High population health demand and evidence of outcomes]	Not a Priority [Low population health demand or weak evidence]
Provider Capabilities	High Performing	Evidence-based healthcare; delivers health strategy Candidate for leading integration	Weak evidence points to disinvestment despite high provider performance Low demand suggests need to establish specific priorities to improve evidence base
	Low Performing	Investment needed to improve provider performance, or seek candidates for relocation, consolidation, or partnering in an integration plan	An area where incumbent providers need to be replaced based on performance, but also where service rationalisation is needed, given either weak evidence or low demand.
Source: after M Tremblay (1993) <i>Finding Winners: Game theory, portfolio analysis and health markets</i> , University of Birmingham, UK.			

The collaboration challenge here lies in agreeing on the linkages between provider performance capabilities, LHIN strategic priorities and what do about the areas where there is potential disagreement between high performance and low demand, and high demand and poor provider performance. Areas of disinvestment will also present a particular challenge in this respect.

3.5 Clarification of Roles and Responsibilities

LHINs fit the WHO definition for purchasers: “a health care body which assesses the needs of a defined population and buys services to meet those needs from providers”. This role distinction is increasing preferred by other health systems for achieving health systems outcomes.

A clear message is that policy implementation requires a clear focus not only on implementation, which is directed toward the policy objectives, but also requires a focus by bodies involved to be oriented toward implementation. Decentralisation must not generate confusion, but instead clarity of purpose amongst empowered organisations.

Specific responsibilities lie with specific bodies, in particular with Ontario's approach that is unlike that of other provinces. Ontario needs to avoid risking confusion with inappropriate lessons from other provincial jurisdictions. Therefore:

- LHINs have final responsibility and accountability for setting outcomes in SAAs, a process which must be clearly communicated with providers
- providers must respect LHIN decision-making responsibility with respect to the implementation of the provincial health strategy
- MOHLTC needs to support and guide the devolved responsibility of LHINs for the provincial health strategy and ensure appropriate measurement and communication of strategy.

Autonomy

Patterns of changing relationships and roles characterise health systems that transform themselves to deliver reformed health care, with heightened focus on outcomes and value to the citizen. To the extent possible, health system actors need to have the autonomy necessary to pursue change. This ranges from a degree of flexibility within the governance arena, to considerably greater flexibility to reconfigure services boundaries, and service delivery methods.

Health system actors must have the degree of autonomy necessary for them to do what is called on them to do including operational responsibility for LHINs in establishing their Board to provide leadership, providers to manage and govern themselves, MOHLTC to sponsor and oversee the system and protect social equity, and lead on policy.

Local Health Strategy

LHINs have the responsibility to undertake local public consultations as part of developing their local strategy, involving consultation processes that will clearly distinguish the role as fundamentally different from the relationship between providers and their local patient constituencies. In particular, LHINs will consult *with the public* on local priorities, preferences and expectations for service delivery, independently of legacy provider configurations, while they will consult *with service providers* to identify service configurations that provide prioritised services in an integrated manner.

While it falls to LHINs how to reconcile the provincial health strategy with local health priorities and plans, the consultative process with providers necessarily will focus on capacity to deliver the

integrated services agreed.

These processes should be seen as distinct from collaborative governance as the process of establishing specific contractual obligations by LHINs with providers, must respect the arm's length nature of contracting, especially when services are tendered.

The LHINs have final decision-making on the content, priorities and actions comprising the local health strategy.

Conflict of Interest

A key element of our analysis is that the Ontario health system can and should thrive on collaboration and collaborative arrangements and that the development of system governance, for the whole system, independently of institutional governance approaches and of any collaboration amongst providers does not present any practical or conceptual contradictions. However, separation of roles is important, and providers and LHINs require board membership that is not in a conflict of interest with respect to the other.

We do not find evidence that the governance responsibilities of LHINs for their statutory duties should be shared with providers through cross-appointments at board level. This also defines important design features of 'system governance'. These processes should be seen as distinct from collaborative governance, as the process of establishing specific contractual and service obligations by LHINs with providers must respect the arm's length nature of contracting, especially when services are subject to a tender specification.

LHINs and Provider Boards should not pursue any cross-appointments of membership.

Provider/MOHLTC relationship

Realignment of focus of providers to be LHIN-facing is essential to their new accountabilities, and may prove challenging in transition. It is essential that providers realign their own institutional governance and managerial arrangements to prioritise their a relationship to the LHINs, with the MOHLTC working through LHINs for individual provider issues where possible.

Providers should reprioritise their strategic, operational and board activities toward the LHINs; there is no need for providers to have a Ministry or Ministerial relationship around their own strategic objectives.

Collaboration with excluded providers

Confusing the priorities of health service providers to provide them with accountability and jurisdiction for system planning is now seen in research and practice as a problem, risking provider-capture of the health system's priorities. The LHINs use of service agreements as the currency for communicating expectations to providers, and linking performance with provider payment is a form of contracting receiving considerable interest and approval.

There may, for instance, be some residual confusion as the system evolves and clarifies relationships, but these areas of conflict need to be monitored and acted upon. Indeed, the long-term ability of the

LHINs to enable further delegation of responsibilities from the MOHLTC, and to take embrace currently excluded providers within an integrated funding model depend on it. The role of sub-purchasing bodies, such as CCACs suggests that early clarification is needed so avoid potential conflict here.

In some provinces that have pursued a gradually increasing process of regionalisation, such as Alberta, excluded groups have been incorporated into regional coverage over time. At this time, it is not clear what relationship would be between non-LHIN providers and the provincial health strategy. International experience has shown the importance of treating the whole provider infrastructure with common standards, rules and participation.

The SAAs, which determine the service delivery priorities and integration plans for Health Service Providers (within the LHIN envelope of accountability), carry the province's priorities down to the local level; articulation of this strategy with the performance of non-LHIN providers is similarly unclear.

This lack of clarity may create tensions as boundaries of service and care are redefined by integration plans.

The MOHLTC and the LHINs should determine at the earliest what governance relationship for strategic planning purposes should apply between LHINs and excluded service providers.

3.6 System-wide issues: Inter-LHIN and Multiple Provider Relationships

The various patterns of changing relationships between providers and LHINs will focus on the multiplicity of LHINs and the multiplicity of providers, and the networks of relationships that they are likely to produce, perhaps similar to what is currently familiar, but novel arrangements should be anticipated as these organisations creatively respond to the challenges. There are unresolved issues here.

Central governments in European countries with decentralised systems are less likely to intervene directly on implementation, preferring to work through the devolved or regional actors. It is acknowledged that a key role for the centre, though, is providing financing of integrating health plans *that cross regional jurisdictions*. This may change if purchasing bodies develop system-wide responsibilities, but it represents an important coordination challenge to ensure system-wide priorities are met by devolved actors. Some states hold formal reserve responsibility for this, by identifying specific areas that are national and those that are not.

Ministry and LHINs

This raises an issue of the role that the centre will adopt – hands-on, hands-off, arm's length. Increasingly, in public sector reform, central governments are 'sponsoring' arm's length bodies as executive agencies, for instance, to act in the public interest on behalf of central government. However, regardless of style of role, the centre cannot ignore system-wide issues in the absence of system-wide coordination.

The MOHLTC would expect these to be its responsibilities to support LHINs:

- providing strategic, policy and regulatory support
- providing supply-side information
- providing scientific advice, and research to support evidence-based decision-making
- providing advice or best-practice guidance
- ensuring system-level coordination, and
- giving a regulatory guarantee of system equality and patient mobility
- ensuring high levels of coordination amongst LHINs in respect of their responsibilities.

The options for dealing with system-wide priorities include:

- LHINs develop provincial level coordination capabilities to address system-wide priorities on behalf of the Ministry
- Ministry:
 - retains responsibility,
 - delegates this task to a new executive agency responsible for province-wide priorities, or
 - engages with the LHINs collectively.

The style of how the Ministry and LHINs address system-wide issues will determine the shape of collaborative governance between LHINs and the Ministry. For example, failure to ensure high levels of planning cohesion and priority setting amongst LHINs may undermine commitment to integration by providers, and indeed could encourage unproductive provider initiatives.

The MOHLTC should coordinate policy implementation with the LHINs.

Managing patient choice and cross-boundary flow

European jurisdictions are very interested in how patient choice can become a force for change. Planning and purchasing bodies are learning how to take into account individual preferences. In most European countries individuals have a relatively free hand in where and how they access the system as it is presented to them, but little engagement in how the system itself is constituted; this represents a key trade-off in the system, by having system design and planning at one level while empowering citizen choice. The tension though is that the rising interest in activity-based funding of hospitals will disconnect institutional viability from global funding, and reconnect it to patient choices interpreted in purchasing intentions. The need, therefore, to consult the public and understand the determinants of citizen choice becomes very important.

For LHINs, this suggests a need to focus carefully on the inter-LHIN governance agenda, should patient-initiated mobility, in addition to formally agreed cross-boundary service delivery to access services, have an impact on local planning. This could be potentially disruptive of the individual LHIN health plans, depending on the extent to which consumer choice influences the service permeability of LHIN boundaries, and of course with whom and how cross-boundary flows are accommodated in LHIN contracts, and how this planning sits collaboratively with other providers.

Patient mobility and portability of benefits between LHINs, though, points to the need to ensure that inter-LHIN governance arrangements are robust enough to support such movement of patients, without undermining the logic of the LHIN policy itself. Institutions of particular relevance here are academic health centres, as they provide services that transcend LHIN boundaries, and may be unique at the provincial level. As well, the provincial geography points to areas where resource redistribution would be called for but for the remoteness and distances involved.

How this plays out over time is beyond the scope of this paper, but represents an important dynamic for collaborative governance arrangements.

Understanding the complexity of LHIN/Provider relationships

LHINs and Providers will relate to each other in a complex network. This will be particular relevance and impact on collaborative governance in the following situations:

- single providers with relationships to multiple LHINs, with a corresponding challenge to the LHINs involved; research hospitals are the principle provider that is involved here;
- multiple providers with a relationship to a single LHIN, presenting a challenge for the number of SAAs involved, plus other coordination challenges for performance management, accountability and outcomes.

The diagram below endeavours to map out what the complexity of questions are in the context of the *one:one* and *many:one*, and indeed *many:many* relationships that exist.

QUESTIONS ABOUT COLLABORATIVE GOVERNANCE RELATIONSHIPS IN A LHIN WORLD			
		LHINs	
		Single LHIN	Many LHINs
Providers	Single Provider	Single SAA with direct governance relationships.	Does one LHIN hold contract for the others? Does the Provider have multiple governance relationships with all the LHINs it serves?
	Many Providers	Does one provider hold the contract for the others? Where many providers are small would a contract 'broker' to hold the contract be needed? How is performance managed especially if the service is spread across many providers? With whom is the primary governance relationship, and what is the incentive for non-participating providers to be engaged in good governance?	What 'pooling' of governance is appropriate to achieve practical governance arrangements?
	Outside the LHIN policy	How does the LHIN engage with non-LHIN-funded providers that become involved in integration solutions?	

The network of potential relationships is complex, and all partners should acknowledge this complexity as central to building good relationships and implementing the provincial health strategy.

3.7 Capacity Building for Good Governance

The collaborative governance challenges are these:

- LHINs *may* have the responsibility to identify and act collectively on priorities at provincial level which fall outside individual LHIN scope of influence (The question to be resolved is will these be delegated from the MOHLTC, or will a coordination mechanism be established?)
- multiple LHIN/multiple provider arrangements transcend individual LHIN boundaries but not necessarily the catchment areas of individual providers that may cover more than one LHIN; an example to be dealt with are academic health centres.
- LHINs collaborate to identify best practice, ensure high standards and avoid geographical variance in health care across the province, with a rigorous focus on evidence-based decision-making
- Consumer primacy/cross-boundary permeability is complicating from operational and governance perspectives and may require special collaborative arrangements to be determined
- Integration plans are likely to alter fundamental legacy relationships and bring into play new providers all of which need to continue to work together in harmony.

Good collaborative governance will, therefore, require good guidance for the present, and to build future capacity. Lessons from other jurisdictions point to the need for guidance to be clear, appropriate and explicit, but not necessarily of the “command and control” type.

Governance must be accessible to measurement and assessment and transparency in order to be seen to be working. As well, the proliferation of subordinate bodies, coordinating bodies, or other efforts to enable collaboration and governance through artificial institutions should be avoided.

This means that:

- Governance is an explicit not an implicit way of working together.
- Governance draws from existing institutional and provincial policy arrangements; it is not a bureaucratic overlay, or additional layer of administration to existing arrangements.

3.7.1 Developing principles to guide good governance

Recently, European policymakers have developed the Madrid Framework as a way to focus a new vision of European health policy and governance. The framework is designed to enhance the potential for European cooperation in establishing common values that can be embraced and implemented on all levels. Drafted in consultation with over 100 health policy experts across Europe, it is not intended as a check list for policy makers but rather is an instrument that can be used to facilitate constructive governance conversations among all stakeholders.

The Madrid Framework’s ‘Twelve Dimensions’ are a collection of qualities, values, principles and concerns, often posed as open questions rather than statements. Their order is dictated by

coherence, not priority, and they are not of equal complexity or range. A prevalent theme throughout is the involvement of citizens in health policy decision making and the implementation process. The value of the Framework is the extent to which it frames the issues that should be the focus of governance discussions, and thereby the areas where collaboration is most needed.

It is clear that the primary aim of the Madrid Framework is to shift the health debate from technical management of targets to the creation and implementation of relevant, supported and sustainable health policies and governance. This is a beneficial development compatible with the direction of health policy implementation in Ontario. There is great potential in dealing with system sustainability by better aligning priorities and resources in a common process, as well as providing a context for advancing innovative solutions to improve productivity, service delivery, quality, and access.

There is considerable synergy between the governance approach in Ontario and the Madrid Framework, such that further work is appropriate to develop a comparable provincial approach.

3.7.2 Developing an information management strategy to support good governance

An 'information value chain' underpins modern healthcare systems, with considerable investment being made at present in clinical information systems. Comparable to this, decision-makers involved in a collaboratively governed system need information to support decision-making – good intentions are not enough. Information is needed beyond contract management to include modelling and forward planning.

Governance information is needed in three key areas:

- on *inputs* (in terms of planning information, consultation priorities, system performance, health status, public health indicators etc.). Good quality and publicly accessible health information and provincial health strategic objectives are necessary.
- on *processes* for developing SAAs, including contract performance, evidence-based support for integration proposals and evaluation of implementations,
- on *outcomes*, showing the link between spending and health impact, in terms of value-for-money, impact, health gain, or other measures of performance; performance on organisational arrangements, networks, and collaboration would fit here.

Additional information to support decision-making is likely to include information on regional (i.e. LHIN-based) labour markets, college and university supply capabilities, impact of medical/diagnostic technologies, medicines pricing and so on. Increasing, therefore, an integrated information strategy is critical depending on both deep and broad data.

INFORMATION AND KNOWLEDGE MANAGEMENT FOR A COLLABORATIVE HEALTH STRATEGY: AN OVERVIEW		
Strategy Formulation	Collaboration Arrangements	Delivery and Outcomes
<p>Information INPUTS to an SAA</p> <p style="text-align: center;">→</p>	<p>PROCESS for developing SAAs</p> <p style="text-align: center;">→</p>	<p>Information OUTCOMES of an SAA</p>
<p>The LHIN/Provider/Public information-based processes for:</p> <ul style="list-style-type: none"> • Consultation • Planning & Strategy Formulation • Priority setting • Determining budgeting and costing • Communicating & Listening • Learning & Change/Improvement 	<p>L+P collaborate in sharing information</p> <ul style="list-style-type: none"> • Population health status, needs, gaps, priorities for action in the present and for the future with information from LHIN/Ministry/other sources • Providers on capacity to deliver • Information on contract performance for LHINS and for providers within the SAA • Priorities for funding, levels of available resources, and allocation methods • Prices versus Costs transparency 	<p>Performance measurement information of SAA</p> <p>Information on performance of LHIN Health Plan against the provincial strategy</p> <p>Revisions to LHIN Health Plan</p> <p>Revisions to SAA & forward SAA planning</p> <p>Communication to:</p> <ul style="list-style-type: none"> • Public • Ministry • Providers • Other LHINs

COLLABORATIVE GOVERNANCE OF ONTARIO'S LHIN-BASED HEALTHCARE SYSTEM

Information of these three types is needed at the provincial level, and at the LHIN level, with specific contractual information by provider or service. Shared use of common information is essential, with agreement on the sources and accuracy of this information.

The MOHLTC may wish to consider establishing a 'governance information system' [GIS] to include web-enabled health system databases, communications and performance information and outcomes reporting to enhance public accountability and to integrate information for LHINs and providers.

4 Conclusion

This paper identifies the approach to governance that is collaborative, and working from accountabilities clarifies the roles of key health system actors. It is compatible with frameworks that have been developed to address governance and policy elsewhere. [M Steffen (2005) *Health Governance in Europe: Issues, Challenges and Theories*, Routledge]

For Ontario, we see specific challenges underlying the new policy and governance framework:

- Health care devolution and consistency of the health care system across LHINs, including the multiplicity of relationships between LHINs and providers.
- Resource constraints are real, and the ability of LHINs to collaborate with each other and with providers will need to focus around common achievement of outcomes.
- The MOHLTC must ensure that public consultations support the integration objectives of the LHIN policy.

The proposed draft guidance on collaborative governance endeavours to present a way forward.

5 APPENDIX: Draft Collaborative Governance Guidance

TOWARDS ROBUST COLLABORATIVE GOVERNANCE OF ONTARIO'S TRANSFORMED HEALTHCARE SYSTEM

Good 'collaborative governance' of Ontario's transformed healthcare system requires good guidance. Lessons from other jurisdictions point to the need for such guidance to be clear, appropriate and explicit, but not necessarily of the "command and control" type. Governance cannot be assumed to be working, but must be accessible to measurement and assessment. As well, the proliferation of subordinate bodies, coordinating bodies, or other efforts to enable collaboration and governance through artificial institutions should be avoided.

Following is draft summary guidance for the Ontario Ministry of Health and Long Term Care (Ministry), the Local Health Integration Networks (LHINs) and service providers, distilled from *Collaborative Governance of Ontario's LHIN-Based Healthcare System* prepared by Trent Gow and Dr. Michael Tremblay for the Ministry of Health and Long Term Care.

5.1 Ministry of Health and Long Term Care

Understand that the Ontario health system can thrive on collaboration and collaborative arrangements and that the development of system governance, for the whole system, independently of institutional governance approaches and of any collaboration amongst providers does not present any practical or conceptual contradictions.

Ensure that the 'collaborative governance of the transformed Ontario healthcare system is based on the key underlying principles of:

- Shared vision and goals,
- Shared planning,
- Transparent, consultative decision-making,
- Shared risks, and
- A more open and responsive organisational and service delivery culture

Develop and put in place a framework of core dimensions of collaborative governance specifically designed to clarify and define roles and responsibilities of those involved in the health system. Clearly communicate to all system organisations and to public. Currently, there is a continuing high level of uncertainty about what the ultimate 'real' role and responsibilities of the various players in the LHIN system will be in important areas, including governance

Respect the devolved responsibility of LHINs for the provincial health strategy and ensure that the strategy is communicated and measured appropriately

Clearly understand and communicate that there is no incompatibility between provider autonomy and independent governance, and high levels of system guidance and governance. Collaborative governance in such an environment will provide a more robust and flexible approach than greater provider consolidation would yield.

Realise that no new formal institutional arrangements with service providers for collaborative governance are needed, whether in the form of further or additional committees or council structures, as this would only serve to further cloud accountability.

Provide targeting and objectives at the provincial level.

Require consistent performance measures across LHINs (to measure LHIN organisational performance, and to measure outcome attainment).

Communicate a consistent mechanism for linking the funding to the targets to enable LHINs to calibrate resourcing with provider attainment of outcomes.

Understand that the Ministry is the guarantor of social values and choices. In that role, therefore, there may be some health service areas which require province-level coordination or which may require an all-LHIN approach to service development and funding.

COLLABORATIVE GOVERNANCE OF ONTARIO'S LHIN-BASED HEALTHCARE SYSTEM

Review existing regulatory frameworks, The MOHLTC may find it helpful to achievement of system goals to determine if system changes are necessary to help LHINs do their work better.

Give priority attention to the inter-LHIN agenda of how LHINs share and collaborate around common goals. Getting the inter-LHIN agenda right will permit the MOHLTC to delegate greater responsibility to LHINs for programmes of province-wide scope.

5.2 Local Health Integration Networks

Understand that the governance responsibilities of LHINs for their statutory duties, including the constitution of their boards, should not be shared with providers, and importantly, LHINs should not have provider representatives on their boards, as this would be a conflict of interest.

Understand that the LHINs use SAAs as the currency for communicating expectations to providers, and linking performance with provider payment. LHINs have final responsibility and accountability for negotiating outcomes in SAAs.

Understand and communicate the need for providers to realign their own institutional governance and managerial arrangements to prioritise their relationship to the LHINs, with the MOHLTC working through LHINs for individual provider issues. However, collective system-wide issues which may necessitate different approaches.

LHINs need to establish an independent relationship with the public in their catchment areas. Recognise that LHINs will have unique responsibility to undertake local public consultations on at least two levels:

- consultation with the public on local priorities, preferences and expectations for service delivery, independently of legacy provider configurations;
- consultation with service providers to identify service configurations that provide prioritised services in an integrated manner.

Understand that collaboration between a LHIN and its service providers is needed in two areas. The first is in developing a shared view of system capabilities and the second on integration priorities, calibrated not to provider capacity, but to the needs identified in the local health strategy. This ensures that the strategy continues to be the focus of collaboration, to avoid collusion in the setting of contracts. The LHIN decides what it wants to do, as is its duty, in negotiation with the providers, and documents this agreement in an SAA. The delivery of SAA outputs comprises provider performance, while achieving the desired outcomes of the SAA defines the LHIN's performance. Together, LHINs and providers will have a shared view of system performance. The process then iterates in the next planning cycle, with new information on performance, capacity and outcomes.

Ensure consistency in performance and strategic focus amongst the LHINs, including consistent performance measures across LHINs (to measure LHIN organisational performance, and to measure outcome attainment),

Understand that the Ministry is the guarantor of social values and choices. In that role, therefore, there may be some health service areas which require province-level coordination or which may require an all-LHIN approach to service development and funding.

Address the role of providers with multiple-LHIN relationships, such as the academic health centres, hospices and other providers for decisions and resourcing, as appropriate, by the Ministry.

Ensure cross-LHIN-boundary patient flows do not conflict with the plan to improve local patient access and reduce waiting.

COLLABORATIVE GOVERNANCE OF ONTARIO'S LHIN-BASED HEALTHCARE SYSTEM

Understand that the role of collaborative planning between LHINs and providers where significant cross-boundary flow of patients exists will raise issues for how individual LHINs view available capacity, and therefore with what organisations are they collaborating and for what purpose; there are undoubtedly financial planning consequences here, too.

Realise that capabilities to address the cross-LHIN and system-wide priorities (including e-health and networking), as robust performance of the LHINs will permit the MOHLTC to delegate additional responsibility to LHINs for services that are province-wide,

Ensure access by the LHINs to consistent and high quality information particular to share information to build inter-LHIN capabilities and compare provider performance. This will need to address the information asymmetry they have with respect to provider-based information on service priorities and performance.

5.3 Service Providers

Service providers are essential for service delivery within the context of identified strategic outcomes by the LHINs.

Providers are likely to engage with LHINs in a negotiation around the contents of individual SAAs, with provincial standards to ensure consistency of provider treatment across the province, by all the LHINs. While it falls to LHINs how to reconcile the provincial health strategy with local health priorities and plans, the consultative process with providers necessarily will focus on capacity to deliver the integrated services agreed. In the end, though, the final decision-making on the content on the local health plan and each SAA is the LHINs. Service providers must respect LHIN decision-making responsibility and authority.

Understand that the governance responsibilities of LHINs for their statutory duties, including the constitution of their Boards, should not be shared with providers, and importantly, LHINs should not have provider representatives on their boards, as this would be a conflict of interest.

In Ontario's transformed healthcare system, the focus of service providers should be on competing for and delivering the outcomes attached to activities set out in the SAA negotiated with the appropriate LHIN(s). There is no guarantee that the existing or proposed global service offering of any potential provider will be funded by the LHIN.

There is a diminished need, if any, for providers to have a Ministry or Ministerial relationship around their own strategic objectives. It is essential for providers to realign their own institutional governance and managerial arrangements to prioritise their relationship to the LHINs, with the MOHLTC working through LHINs for individual provider issues.

Legacy service provider associations must adapt to and support the new governance realities at a LHIN level. Currently, some such associations may have 'collaborative governance' on their agendas as a way to continue with traditional untransformed patterns of service delivery. Diluting the governance responsibilities of the LHINs through greater apparent collective decision-making will only serve to undermine the objectives of the province's health strategy. This cannot be encouraged and in fact, there needs to be clear, direct, early communication with service providers to advance the LHIN-based transformation of the healthcare system.

There is a myriad of existing service providers in each LHIN. Efficiency, effectiveness and success are strong incentives for these organisations to take the initiative to combine the governance of their operations formally to create a competitive critical mass going forward.

6 APPENDIX: The Madrid Framework: Twelve Dimensions of Health Targeting in Europe for Policy and Governance and Their Relevancy to Ontario

The *Madrid Framework* focuses on a new vision of European health policy and governance. It was drafted in May 2003 by the MSD European Health Targets Advisory Board, and presented to the European Commission for Health and Consumer Protection in October 2004. [M Marinker (2005) The Madrid Framework, *Eurohealth* 11(1):2-5]

The 'Twelve Dimensions' are a collection of qualities, values, principles and concerns, often posed as open questions rather than statements. Their order is dictated by coherence, not priority, and they are not of equal complexity or range. A prevalent theme throughout the *Madrid Framework* is the involvement of citizens in health policy decision making and the implementation process. For each dimension, we have identified core governance-related questions for further consideration in the Ontario context.

1. Health Gain

Governments have a duty to protect the health of their citizens and to enable them to improve their individual and collective health. This is the *raison d'être* of health policy and governance. Policies may address health promotion or specific health deficits. Criteria for judging improvement should be made explicit, with specific quantifiable targets and outcomes.

Is it clear how the implementation of the targets is to be evaluated?

2. Equity and Fairness

Inequalities in health closely mirror inequalities in socioeconomic status. Inequalities, both biological and political, may also be related to gender, age and ethnicity. Health policies should strive to address such inequities in health and access to care.

To what extent is the concern for fairness reflected in structures for governance?

3. Choice

While most health policies are directed to large populations, sometimes to large regions and whole nations, individual citizens have unique needs and priorities. What is deemed best for the group will only randomly be best for the individual. European citizens are increasingly aware of their rights as patients and are demanding greater participation in decisions affecting their health care.

What are the trade offs concerning collective interest versus individuals' priorities?

4. Responsiveness to Society

All stakeholders, citizens and patients must be actively involved in decision-making. This requires transparency in decision making, honesty, high quality information about choices and outcomes and education on how to access, interpret and utilise this information from both public and private sources.

Is there “common ownership” of policies?

Are citizens engaged in priority setting?

What are the mechanisms to ensure that the public’s views are heard?

5. Investment in Health

Government must see public health as a vital national resource. Government must be stewards of health. Government support must be negotiated across all sectors.

What is the best way to commit financial, human and intellectual resources to reflect the views of society?

6. Evidence

Successful governance requires appropriate and reliable data that are comparable over time and comparable between locations. This information makes it feasible to track health and social trends that unfold over long periods. Health targets are moving targets. Foresight will require more than reliable data about past trends – and may require a “public health intuitive judgment” to anticipate future challenges.

Are there appropriate systems in place to collect and compare reliable health data?

Are there examples of ‘intuitive judgment’ that offer lessons to be learned and which can inform priorities?

7. Efficiency

Governments have a dual accountability to protect and improve health in policy and implementation and to ensure optimal use of resources entrusted to it. Health programs should strive to achieve the maximum improvement possible in order to make the best use of limited resources. Governments should not constrain flexibility. Efficiency is concerned with the effectiveness of interventions, the priority given to them and the ways in which they are implemented.

How is efficiency of the targeting enterprise (MOHLTC and LHINs) to be assessed?

How do we relate the ‘health gain’ to economic or social cost?

In seeking efficiency, are managerial energies being diverted from more important health priorities?

8. Intersectoral Governance

At regional and local levels, there is a need for cooperation that is inclusive of governmental, private, voluntary sectors and other elements of civil society, including housing, education, the environment etc.

Have all stakeholders who could contribute to the targeting and implementation process been involved?

Are there effective systems for communication and decision-making?

Are there benchmarks for cooperation between different sectors and organisations and new synergies in tackling old problems?

9. Local Participation

Health targeting requires a fine balance between the exercise of responsibility by government at all levels, and the ability of local actors to interpret and implement goals according to need.

Is there appropriate and sufficient local involvement in the genesis of policies, the method of implementing them and the forms of monitoring?

Are there measures in place to develop the role of local communities and local systems in health targets?

10. Sustainability

Since most health policies are long term exercises, provisions must be made to sustain political, organisational, societal and personal “motivation” over the course of time (and through successive governments). In most long term enterprises there can be a falling off of commitment and energy. How can this be anticipated and counteracted?

How will targeted health gains be sustained beyond the period of active targeting, and by whom?

How will improvements in interagency relationships be sustained in the long term?

11. Interdependency

In our globalised world, no country, region or locality is an island. There are political, biological, technical, corporate and media interdependencies at every level. Health and health services are influenced by global concerns such as immigration, workforce mobility, air quality and international agreements that are recognising the links between health and other policies. Local, regional and national health policies can have unintended affects beyond their own boundaries.

What evidence is there of the influence of interdependencies in modifying policy and governance?

12. Complexity and Creativity

Specified “tight ends” may need “loose means”. Successful implementation encourages opportunistic action, innovations and requires flexibility of thought on the part of stakeholders and institutions. Health governance is not a securely predictable and linear exercise: many of the contextual factors may change over the period of targeting – sometimes quite rapidly and unexpectedly

How are the complexities and uncertainties of governance being handled?

What elements of current implementation are novel and experimental?

What effort is being made to describe, evaluate and disseminate innovation?

7 Appendix: Governance Experience from the European Union¹

European Union member states are of particular relevance to the transformation plans in Ontario for a variety of reasons:

- Ontario shares similar social priorities, policy drivers and concerns with European nations.
- The LHIN strategy is closer to reform developments in Europe than to regionalisation strategies in other Canadian provinces.
- The devolution of authority in Ontario offers greater learning from legal equivalences in Europe.

These conclusions are drawn despite many prevailing tendencies to look to US jurisdictions for reform, but where we find little common social or public purpose, or reform lessons on the funding side, where EU member states are pursuing sustained reform.

7.1 Health Care Devolution in European Union Member States

The process of devolution of government power, including health care governance, is widespread in the EU.

This process of institutional change has given rise both to new regional elected governments with considerable powers (UK, Spain, Italy, France, Belgium and Portugal); and to strengthened county or municipal local governments (Denmark, Finland, Norway and Sweden). Since the mid-1990s, after decades of centralised communist rule, Central and Eastern Europe have jumped on board, and undertaken devolution of executive and fiscal powers to local and regional governments, following the recommendations of the World Bank.

Although devolution is one of the most relevant transformations in the governance of modern health care in Europe since its inception (the early 1960s in Nordic countries), it is not immediately clear what effect the process of devolution has had on European health care in general.

In recent years there has been expanding research on what devolution means in different countries (vis-à-vis federalism and traditionally strong local government), on how it has evolved and where it prevails, on its causes, and on factors contributing to its successes or failures.

The European Commission Directorate for Health and Consumer Protection [DG Sanco: ec.europa.eu/dgs/health_consumer/index_en.htm] does not yet have a clear and simple definition or summary of devolved systems and the policy instruments and institutional tools involved in the dynamics of health care devolution.

Governance lessons for Ontario's LHINs and MOHLTC can be found from looking at specific aspects of European health care devolution, and how it evolved over time. This would include trends in countries which have long experience in devolution (the Nordic countries- Denmark

¹ The authors gratefully acknowledge the valuable contribution of Mr Dan Dempster in this research and analysis.

Finland, Norway, Sweden since the early 1960s – and the two devolved southern European countries – Italy and Spain, since the mid-late 1970s.

All these countries share an important common characteristic, i.e., a tax funded National Health System that guarantees universal access to health care -- although they differ in the way they structure devolution.

It is now clear that in health care, devolution constitutes *the* key governance mechanism mainly in tax funded European countries where the public sector performs the roles of financing, purchasing and providing care. In these systems, devolution has been a key reform issue politically. This is now particularly the case in the UK, Greece and Portugal where devolution entered their political agendas only in the last years of the 20th century. In contrast, in Social Health Insurance countries, (such as Germany and Switzerland) delegation to mutual funds and insurers' and providers' associations evolved as the main governance mechanism.

Since devolved government in Europe results from real powers being transferred 'downwards' to smaller units, devolution often brings about a process of continuous revisions of power sharing arrangements, as seen in the Nordic Countries, Spain and Italy. Devolution, therefore, can be considered a more unstable, yet flexible governance mechanism than centralised (command-and-control) approaches.

In developing principles on role clarification for LHINs in Ontario, it is significant to note that 'devolution' in NHS countries is not exactly the same as 'decentralisation'. Obviously, what devolution shares with decentralisation is the process that directly causes it – i.e., the transfer of powers from the central government downwards to smaller units. decentralisation may include, e.g., delegation to a central government's regional branches, delegation to independent agencies and privatisation, with transfer of ownership to public or private enterprises. In decentralisation, the nature of the powers transferred is largely administrative or managerial rather than political, as in devolution.

The accountability mechanisms for decentralisation and devolution tend to be different too. Administrative decentralisation relies on top down hierarchical or contractual mechanisms. In most devolved systems, however, central governments frame legislation and set rules for the system, then leave responsibility for outcomes and governance to autonomous regions. Devolution accountability mechanisms rely primarily on 'bottom up' citizen's control through consultation and political participation and so devolved health regions have a natural connection with the public not with providers. Central governments essentially pay the bills and ensure overall system cohesion and performance.

In some devolved countries, sub-national [Europeans use 'sub-national' instead of 'regional', since health care in Europe is governed and delivered not only through regions, but also through counties, municipalities etc.] units enjoy more political and fiscal powers than the member states in many federations (e.g. Spain vs. Germany in health care). In Spain, Navarre and the Basque country have almost full tax freedoms and manage their health budgets themselves. Contrary to what is sometimes assumed, in federated countries such as Germany and Switzerland, the health care powers of sub-national governments are very weak – which, of course, is consistent with the important role that insurers' and providers' associations play in health systems governance in SHI countries. The German Länder have only relevant powers in the field of public health, and hospital capability

planning and development. Reforms in Germany, though, are likely to see greater control moving to each Land, from the sickness funds.

Broadly speaking, there have emerged three main types of accountability mechanisms in multi level devolved governance in Europe.

The first mechanism is **vertical bottom up accountability**. This is the key mechanism in federations and most devolved governments. It includes both democratic accountability – through voting and direct political participation of citizens- and fiscal accountability, which operates through taxation or other revenue raising mechanisms. This is a clear power transfer with the intention of building capacity.

The second mechanism is **horizontal accountability**, which includes collaboration to identify best practice, and which depends on competition and mutual oversight among regions or municipalities. This is essentially a risk transfer mechanism, resembles a 'checks and balances system', and is based on all regions/localities having similar and clear information on common governance tasks.

The third mechanism is **vertical top down accountability**, a remnant from centralised rule but still targeted under local self-rule to guarantee that all citizen's rights are preserved and that local minority interests do not overrule majority preferences and national public health issues. This third accountability mechanism is to ensure equity and effective coordination in all sub-national units.

In devolved health care systems, size also matters. Devolved NHS countries in Europe differ considerably in terms of the size of the sub-national governments, which are in charge of health care, and if less markedly in terms of distribution of powers. Finland, e.g., is the only country in Europe in which most health care powers are in the hands of small municipalities. Norway is also unique in that health care is split up between two local government tiers: until 2002, counties were in charge of hospitals; while municipalities are responsible for primary and community care. Sweden and Denmark (until 2007) have concentrated power over health at the county council level.

In Italy and Spain, relatively large regions are in charge of health care. Therefore, the average size of devolved care regions in Europe varies widely. In Finland, municipalities have an average size of only 5000 inhabitants. In Spain, the seven special regions (e.g. the Basque country) all have populations of over 2 million inhabitants.

What is interesting is that the Nordic countries, and Spain and Italy, have proceeded through several comparable stages in the process of devolution in health care. They have proceeded through all three accountability mechanisms noted above. From the '60s to the '80s, the Nordic countries were engaged in the first mechanism, i.e. vertical bottom up accountability. From the late 1980s to the late 1990s, they were engaged in the second mechanism, horizontal accountability; and in the 21st century, Norway, and to a lesser extent Denmark, are entering a third mechanism, vertical top down accountability, at least in some aspects of health care.

In Norway in 2002, there was a transfer of ownership and management of hospitals from the counties to the central Norwegian government. The recentralisation of hospitals was a response to the longstanding demand for greater patient choice, and tried to address weak coordination among levels of governments, differences in utilisation and accessibility rates across local and regional governments, and increasing dissatisfaction among the population due to growing waiting lists. In

2004, Denmark followed Norway's example and launched a package of reforms, to be implemented by 2007, which move towards recentralisation. Reforms include, e.g., the suppression of county councils to be replaced by 5 new health regions, with democratically elected boards but with no taxation powers; and a requirement that the central government clearly communicate national health strategy to the regions.

Devolution, therefore, one of the most relevant transformations in the governance of modern health care, is an unfinished and ongoing process that involves the constant search for a more efficient balance between the centre and the region/locality. Recentralising reforms in Norway and Denmark indicate that devolution can be a reversible process – at least in smaller tax-funded systems.

7.2 Management Information for Governance: Data Collection on Health Care Indicators at the Sub-national Level in the EU

Successful governance requires appropriate, comparable and reliable data that are comparable over time and between locations. Comparable data collection, however, is an ongoing problem in the EU.

The regions/sub-national units of the EU are gaining in importance in both political and administrative terms in the 21st Century. In the field of health monitoring, this raises a problem: how can there be a useful collection and exchange of health indicators, at sub-national levels across Europe, that would allow professionals and decision makers to place their own region within the wider context of all other regions across the EU, to assess, e.g., equity, quality and service accessibility outcomes?

A set of sub-national health indicators for the EU is being developed by ISARE (Indicateurs de Santé des Régions Européennes) [www.isare.org] and Eurostat [epp.eurostat.ec.europa.eu/portal/page?_pageid=1090,30070682,1090_33076576&_dad=portal&_sc_hema=PORTAL]. Socio-economic regions are defined in very different ways from one regional, provincial or local government to another, and from one member EU state to another, which has a direct impact on the political and administrative management of health issues. In Spain large regional governments have a great deal of autonomy, and manage their own health budgets themselves. The situation is very similar for Belgium. Healthcare management continues to reorganise in the English NHS. In Sweden, healthcare is the responsibility of county councils; and in Finland, it is in the hands of small municipalities.

Another difficulty with statistics on health and medical/hospital services at sub-national levels stems from the fact that regional, provincial or local government statistics do not tally with NUTS (Nomenclature des Unités Territoriales Statistiques) classification. [ec.europa.eu/comm/eurostat/ramon/nuts/basicnuts_regions_en.html]

8 APPENDIX: Governance Experience from other Canadian Provinces²

With the recent development and emergence of the LHINs in Ontario, regionalisation of healthcare systems has taken place in all ten provinces in Canada, with most significant restructuring changes implemented within the last ten years.

The effect of regionalisation on local community healthcare governance is now of particular importance in Ontario, and it is essential to reframe the understanding and practice of governance across the LHIN system to include shared leadership and accountability among LHIN and CCAC Navigators and community healthcare providers.

While other provinces have not had to contend with developing a practical strategy to achieve collaborative governance, there are lessons to be learned from other provinces in terms of the governance relationship between Regional Health Authorities (RHAs) and community healthcare providers and the Ministry/government).

- The impact of regionalisation on locally governed healthcare providers has been mixed across Canada. In Quebec, the 149 CLSCs have lost local community governance and are now merged with other organisations to form a network agency within a regional structural authority.
- Excluding Quebec, it seems most reputable community healthcare providers in existence before regionalisation have retained local governance structures, but have contractual agreements with their local RHAs for various levels of funding.
- Excluding Ontario, there appears to be no expansion of community governed CHCs, e.g. New CHCs have been created, but they are under the governance of RHA boards.
- There is a trend towards integration and alignment of services focusing on primary health care. Alberta has initiated primary health care networks through a tripartite agreement between the Ministry, Alberta Medical Association and RHAs.
- Provincial governments say they want community participation in health care planning, but effective community engagement strategies are not consistent. Issues tend to be driven by the priorities of governments and/or RHAs. (Notable exceptions are in Vancouver Coastal Health, Calgary Health Region and Winnipeg Regional Health Authority, which have well developed community engagement frameworks)

8.1 regionalisation and Challenges to Effective Collaborative Governance

Research has identified four main features common to all regional health care systems in Canada, which though obvious, must be 'on the table' as we move forward to build a practical strategy to achieve collaborative governance of Ontario's newly integrated healthcare system. [S Lewis & D Kouri (2004) regionalisation: Making Sense of the Canadian Experience, *Healthcare Papers* 5(1):12-31] Ontario's system is regional, but is unlike all the other regional jurisdictions in Canada and reflects

²The authors gratefully acknowledge the valuable contribution of Mr Dan Dempster in this research and analysis.

reform from European experience more than the rest of Canada:

- Regions are defined by geography.
- Their existence and authority are at the pleasure of the provincial government. In other words, they are *devolved* authorities, and not self defining entities (e.g. Toronto is service by five LHINs).
- They consolidate authority at the regional level, authority previously distributed among many programs and communities.
- They are responsible for planning, funding and integrating a wide range of health services.

8.1.1 Alberta

Since 2003, Alberta has nine RHAs, which are responsible for acute care, continuing care, community health services and public health programs.

Alberta experimented with a mix of 2/3 elected and 1/3 appointed board members, but currently all RHA board members are appointed, and paid, with the length of term to be determined by the Minister.

The RHAs' mandate include: promoting health, planning, prioritising, and funding programs and services, reporting on performance and demonstrating accountability.

To demonstrate accountability, RHAs are required by law to develop:

- a three-year Health Plan to provide authorities with a mechanism to set out the long-term direction for effective governance of it's health region;
- a Business Plan to communicate how the RHA expects to achieve the expected results of the Health Plan;
- a Capital Plan to improve overall planning and management of the health infrastructure;
- an Annual Report to report on how the RHA has discharged its legislated responsibilities, to highlight achievements, and to communicate to the residents of the region and the people of Alberta.

The Health and Business Plans in particular indicate how RHAs align and work with each other and their communities, community health councils, professional committees and other stakeholders.

Alberta is the first province in Canada to bring about a fundamental change in how the Ministry, RHAs, and physicians align to improve patient access to primary care. Although the Alberta Government, Alberta Medical Association and RHAs signed an historic eight-year agreement, there appears to be little evidence yet of direct community input into service priorities or decision making of these networks.

RHAs and Community Healthcare Providers

Longstanding primary health care organisations, such as two CHCs in Calgary, maintained their community boards and local governance structure throughout the regionalisation process. These

CHCs now receive a significant portion of their funding through a contract with their RHA.

Since regionalisation, a number of new CHCs have been established, particularly in Edmonton and Calgary. The new CHCs, which have a broader range of health services, are governed by the RHAs. There are now, e.g., 13 CHCs in Calgary under RHA governance. So far, attempts to establish new locally governed CHCs have been rejected by the RHAs and the government.

This does not mean the end of community engagement. The Alberta government requires each RHA to have Community Health Councils (similar to the former DHCs in Ontario). These Councils are advisory bodies appointed by each RHA Board to provide citizen input into health planning and direction setting. In the Capital Health Region in Edmonton, there are 10 geographically based Community Health Councils.

8.1.2 Quebec

Quebec has the longest history and most experience with regionalisation of health care in Canada – and undergone the most changes since 1971.

In 2004, the Ministry of Health and Social Services (MSSS) established 95 local service networks across 18 regions. At the same time, at the heart of the local service networks, 95 new institutions known as Health and Social Service Centres (CSSSs) were created by merging local community health centres (CLSCs), residential and long-term care centres (CHSLDs) and general hospital centres (CHSGSs). A board of directors governs each CSSS and is accountable to their respective regional agency.

In contrast to Alberta, where community based boards of CHCs were grandfathered in through regional restructuring, all 149 CLSCs lost their local governance in 2004 when they merged with other health organisations to form the new Health and Social Service Centres (CSSSs). In Montreal, for instance, there were once 29 CLSCs – now there are 12 CSSSs.

CSSS boards are held responsible and accountable for large populations and a great range of services. Each CSSS must ensure that that the population in its territory has access to medical services, general and specialised hospital services and social services. Each CSSS is required by law to enter into service agreements with other partners in its local service network (medical clinics, family medicine groups, youth protection centres, community organisations, university hospital centres etc.) to provide the services required by the population, including those it cannot provide on its own. This then forms the 'local service network'.

Guidelines for collaboration between the CSSSs and the other players in the local service network are guided by the Ministry. Part of the MSSS's comprehensive nine-point mission is

- Implementing the management frameworks necessary for efficient and effective resource use.
- Coordinating cross-sectoral activities.

(source: www.msss.gouv.qc.ca/en/ministere/mission.php)

8.1.3 British Columbia

In 2001, the B.C health system merged the previous 52 health authorities and implemented a new

governance and management structure for the health system. There are now six RHAs: five geographic RHAs that govern, plan and coordinate services regionally through 16 health service delivery areas; and one provincial health service authority, that coordinates or and/or provides provincial programs and specialised services.

Board members of the RHAs are appointed and are responsible for identifying population health needs, planning programs and services, ensuring programs and services are properly funded and managed, and meeting performance objectives. Each RHA has a senior executive management team that plays an important role in decision making at the operational level.

As in Alberta, many well established community based healthcare providers maintained their local governance structure after regional restructuring. For example, there were two locally governed CHCs in Vancouver, which still operate as such. What is interesting is that during the time of regionalisation, the government emphasised strengthening infrastructure in the community, and many new CHCs were established across the province. In Vancouver, e.g., there are now 10 CHCs.

The new CHCs are much larger than the older CHCs and offer a different mix of services. They also are directly under the RHA governance umbrella, and are not community governed – and their staff members are employees of the RHA. Older CHCs are linked by a transfer payment agreement with the RHA for some of their revenue. In Vancouver, the older CHCs struggle to find additional funds to maintain viable operations, and are losing visibility with the Ministry. Recently, Vancouver Coastal Health (VCH) made an unsuccessful offer to bring locally governed CHCs under their umbrella.

One drawback of B.C.'s five large geographic RHAs is the size and scope of its responsibilities and their remoteness from local communities. One mechanism to involve citizens locally is through community engagement strategies – but community engagement within each RHA has apparently had varying degrees of success.

Vancouver Coastal Health [VCH]

This is one RHA that has a well developed Community Engagement Framework, a Senior Management team supporting it and staff to implement it in all domains of the system i.e. community health, mental health, residential and acute care (www.vch.ca). The role of the Community Engagement Team (Regional Director, Community Developers, Community Health Nurses, and others) is to ensure public participation and community involvement in priority areas of policy, planning and operations. Requests for community engagement are identified from various sources including clinical staff, management, VCH board and from the community itself. Depending on the issue, a variety of methods is used to engage the public and seek input and advice.

Therefore, the approach taken by VCH was to advocate for an effective community engagement model, rather than push for expanded collaborative local community governance. It appears that, from the perspective of VCH, the community engagement model in Vancouver has resulted in more meaningful, diverse participation of citizens than a community governance model ever could achieve, in that it ensures the right people are included on the right issues.