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Steering and Rowing in Health Care: The Devolution Option?

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Publicly funded health care systems are often the subject of heated policy debates. All too often (particularly in Canada), these debates focus on the prohibitive costs, the resultant taxation levels, and the questionable efficiency and outcomes associated with a publicly funded system. Moreover, the institutionalization of the system and the entrenchment of its many stakeholders make effecting change particularly difficult. In this article, the authors begin with an assessment of the drawbacks of the Canadian health care system in the federal-provincial context and its resulting gaps in governance (steering), in management (rowing), and in overall accountability (apart from that offered by periodic elections). They conclude that because of the above factors and the public's personal investment in a perceived health care entitlement, policymakers tend to avoid long-term changes to the system in favour of such short-term solutions as increased funding or reductions in funded services. If fixing health care is the goal, governments must embrace more fundamental change. Devolution is a process through which governments give up their hold on the detailed management of the health care system, in exchange for more involvement in its governance. In this way, it allows the government to steer—by defining values, setting goals and objectives, and evaluating outcomes and efficiencies of the system—while allowing those that deliver health care to determine how best to do so (in other words, allowing the rowers to row). In light of the successes and failures of devolution in other jurisdictions, the authors then present a model for devolution that they argue will allow the Canadian health care system to flourish. Although devolution is only one part of the solution, it is a fundamental part.

Introduction

I. Governance, Management and Accountability Gaps in Health Care

A. Governance

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Introduction

No issue is more central to good governance in health care than accountability. The participants in and beneficiaries of a governed enterprise should know who is in charge and how decisions are being made. With respect to publicly funded services, a high level of accountability ensures that a government acts as a public servant. In Canada, publicly funded Medicare—the pooling of resources to ensure universal and comprehensive provision of health care based on need rather than ability to pay—is heralded as a singular achievement of governments and the citizenry. Nevertheless, the principle of accountability is poorly reflected in Canadian Medicare. For example, where does a patient turn when told there is no hospital bed available? To her physician, the hospital, or the provincial government of the day

as represented by the Minister of Health? When a nurse is worried about the impact of a part-time rather than full-time employment policy, to whom does she turn for answers? Does she look to the collective agreement, bargaining agent, hospital CEO or board, or to the provincial Minister of Health? Should these protagonists look, *in extremis*, to the federal Minister of Health? The answers to these inquiries are ambiguous at best; at worst, there are no answers. Who is accountable for health care?

It is trite but nonetheless true that those who govern and those who manage should be accountable for their decisions and actions. In Canada, provincial governments believe that they are in charge of both the steering and the rowing¹ of health care and that they are accountable for those roles through the electoral process. Democracy is, of course, a form of accountability, but it provides accountability only for the “big picture” of health care, and such accountability is diluted by the fact that health care management and governance becomes intermingled with many other governmental decisions and responsibilities. Answering to the electorate every four years does not provide accountability for most of the decisions and actions designed to govern and manage a health care system. A citizen may shift her vote from one party to another because of big picture principles, such as support for two-tiered health care or private clinics. However, the failure of a local hospital to streamline its information systems, the stalling of primary care reform in a remote community, or a gynecologist’s performance of more Caesarean sections than are medically necessary are issues unlikely to motivate a citizen to shift her vote. As a result, other accountability mechanisms are needed that are appropriate to the type of decision-maker and the nature of the decision or action. In health care, decisions can be characterized as either governance (steering) or management (rowing).

In response to this accountability gap in the governance and management of health care systems, many jurisdictions have embraced the devolution of management responsibility and authority from central government administrations to regional health authorities (RHAs), integrated health systems (IHSs), municipal governments, primary care

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1. David Osborne & Ted Gaebler, *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector* (New York: Plume, 1993).

groups, and sickness funds. Devolution “represents a significant innovation in health care governance, and entail[s] a shift in the role of central government from hands-on regulation and control [rowing] to external steering.”² The Canadian health care system gives the provinces, rather than the federal government, primary control of health insurance and health care delivery. Currently, all provinces but one have adopted a form of devolution, primarily of management responsibilities, as part of their reform initiatives. The lone wolf is Ontario, Canada’s most populous province.

The current state and future of Medicare perch atop the political agenda. Ontario is experiencing a simultaneous increase in the size and age of its population,³ suggesting that recent increases in the rate of spending on health care are unlikely to be a temporary phenomenon. In 2001, the government of the day warned that at the current rate of increase, health spending would consume sixty percent of the province’s operating budget within five years.⁴ “Crisis” rhetoric fuels demands for something to be done, not only about the sustainability of publicly funded health care, but also about the extent to which health care spending is crowding out other social spending on education, income supports, and the like, all of which in the long run will have important effects on health.

Effectively, the Ontario government has four choices. The first is simply to spend more money on health care, by either raising taxes or cutting other programs. More money will certainly buy political calm in the short-term. However, if money is used only to placate the demands of the various stakeholders for higher compensation rates, then over the long term the structure and dynamics of the system will ensure that the

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2. Ana Rico & Wendy Wisbaum, “Radical Devolution in Finnish Health Care” (Summer 2002) 4 Euro Observer 6, online: Euro Observer <<http://www.who.dk/Document/Obs/Obsummer2002.pdf>>.

3. See David Baxter & John Smerdon, *Ontario’s Population in the Next Four Decades: Eighteen Million Strong and Growing* (Vancouver: The Urban Futures Institute, 1999), online: The Urban Futures Institute <<http://www.urbanfutures.com/Institute/abstracts/Report%2039%20Ontario%20Population.pdf>>.

4. Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, 7 (30 April 2001) at 282 (Hon. Tony Clement), online: Legislative Assembly of Ontario Hansard <http://www.ontla.on.ca/hansard/house_debates/37_parl/session2/L007.htm>.

pleas for more money will never abate. The second option is to shift costs from the public insurance system to the users of that system through various forms of privatization, including imposing user charges and allowing two-tiered insurance. There is a furious debate about privatization in health care,⁵ and at the risk of over-simplifying both our position on this issue and the debate *per se*, we will simply state we do not advocate this as a policy objective. Privatization could help reduce public-sector spending, but it would not provide an incentive for greater overall efficiency and would raise clear distributional concerns. Moreover, such a move would be contrary to the *Canada Health Act*⁶ (CHA), and any gains made for Ontario's public purse would be lost if the federal government were to withhold equivalent transfer payments to the province.⁷ The third choice is to define more rigorously medically necessary health care services that will attract public funding and to exclude or restrict services of relatively small benefit.⁸ This, we believe, is something that must occur over the long term, not only as a mechanism to control costs, but also to allow newer technologies and treatments to supplant older ones. Once again, this is extremely hard to

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5. See e.g. the discussion of privatization options in health care in Canada, Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians—The Federal Role, Volume 6: Recommendations for Reform* (Ottawa: Canada Communication Group, 2002), c. 1 (Chair: The Honourable Michael J. Kirby, Deputy-chair: The Honourable Marjory LeBreton) [Kirby Report]. See also Alberta, *Report of the Premier's Advisory Council on Health* (Edmonton: Premier's Advisory Council on Health, 2002) (Chair: Rt. Hon. Don Mazankowski), online: Premier's Advisory Council on Health for Alberta <<http://www.premiersadvisory.com/reform.html>> [Mazankowski Report].

6. R.S.C. 1985, c. C-6.

7. The present Liberal government in Ontario has explicitly disavowed increased privatization. See e.g. the news release by the Ontario government announcing the introduction of the "Commitment to the Future of Medicare Act." Health Minister George Smitherman is quoted as saying, "[w]e are slamming the door shut on two-tier, pay-your-way-to-the-front-of-the-line health care in Ontario . . . [t]his bill would enshrine into law what we already deeply believe in our hearts—that every member of our society has an equal right to quality health care based on need, not income." See online: Government of Ontario <http://ogov.newswire.ca/ontario/GPOE/2003/11/27/c7199.html?lmatch=&lang=_e.html#e>.

8. For a discussion see the working papers, online: Defining the Medicare Basket <<http://www.law.utoronto.ca/healthlaw/basket/>>.

do given the strong political, legal, and other incentives to maintain the status quo. The fourth option is to improve the technical efficiency of the system, not just on the part of the care providers, but also on the part of those who manage or govern the system. It is in this latter regard that we challenge the Ontario government's choice to reject devolution as an option.⁹

This paper examines the reasons for and consequences of Ontario's reluctance to adopt devolution. Part I identifies and explains the consequences of the governance, management and accountability gaps in health care. We begin by clarifying what we mean by governance, management and accountability, as these terms are often used but infrequently defined in public discourse. In Part II, we describe the current lines of responsibility and accountability in Canada's health care system, focusing on how Canadian federalism can distort attempts at rational health care reform. In light of these considerations, we also analyze the present legislative framework for the governance of health care in Ontario. In Part III we explore the advantages and disadvantages of devolution. We illustrate this discussion with Canadian and international examples. Throughout the section, features of Ontario's health care system are used to demonstrate how the advantages of devolution may be realized in practice, and the potential disadvantages avoided or minimized. We then proceed to analyze the devolution experience in other Canadian provinces, identifying successes, failures and barriers to effective reform.

In the final part of this paper, we discuss the broader reforms necessary to integrate a devolution framework effectively within a health care system. What is clear from the stacks of articles and reports written on health care reform is that there is no magic elixir for the problems of publicly funded Medicare. Any proposed reform, including devolution, constitutes only part of a large puzzle. Reform requires a series of interlocking initiatives that will improve the efficiency and effectiveness of the system over time. These complementary reforms include shifting the debate from funding to governance, clarifying the roles of both the federal and provincial governments and developing an incentive-based and information-based system that is geared more toward rewarding

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9. It seems our challenge has been taken up. See Postscript, below.

improvements in health care outcomes than to the delivery of health care services.

I: Governance, Management and Accountability Gaps in Health Care

A. Definitions

(i) Governance

The World Health Organization (WHO) recently emphasized the importance of good governance in health care and the need for both good and smart stewardship on the part of governments: “The ultimate responsibility for the overall performance of a country’s health system must always lie with government.”¹⁰ Similarly, one commentary has noted:

Despite considerable disciplinary and ideological disagreement there has been a common thread of interest in how changes in state behaviour can help to produce better health-related outcomes. Nearly all observers agree that both the configuration and the application of state authority in the health sector should be realigned so as to achieve desired policy objectives. The intended outcome has strong overtones of desire for what is frequently termed good governance, which in turn involves policy-making that serves the public interest.¹¹

We equate governance with leadership, and with accountability for the effectiveness of that leadership and for the performance of the organization being led. Governance primarily includes defining the

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10. Osborne & Gaebler, *supra* note 1, cited in World Health Organization, *The World Health Report 2000: Health Systems: Improving Performance* (Geneva: World Health Organization, 2000), online: World Health Organization <<http://www.who.int/whr2001/2001/archives/2000/en/pdf/chapter6.pdf>> at 119 [*World Health Report 2000*].

11. Richard B. Saltman & Odile Ferroussier-Davis, “The Concept of Stewardship in Health Policy” *Bulletin of the World Health Organization* 78:6 (2000) 732, online: World Health Organization <[http://whqlibdoc.who.int/bulletin/2000/Number%206/78\(6\)732-739.pdf](http://whqlibdoc.who.int/bulletin/2000/Number%206/78(6)732-739.pdf)> .

vision and mission of the enterprise, along with the goals that must be satisfied to achieve them. As applied to governments and health care, the term includes articulating both the values of the health care system and the policies that derive from those values and that apply to the choices of decision-makers at all levels in the system. A health ministry plays the primary role of steward, with responsibility for policy-making and coordination. It must articulate the values of Medicare and use those values to help choose policies that will best achieve the desired outcomes. Governments should be accountable to both citizens and patients for their performance as governors. However, as we discuss below, they should not assume the role of managers, for there are no mechanisms to hold governments accountable for their actions in managerial roles.

(ii) Management

Whereas governance deals primarily with what is to be done in accordance with what values, management deals primarily with how policies are implemented. Management is an executive function with authority for the operational control and direction of activities. It requires a range of skills, general and specialized, that are necessary to design and direct organizational structure, budgeting and operational planning, finances, human and physical resources, internal and external communication, record-keeping, evaluation of progress and so on. Managers are clearly accountable to governors, but they should also be directly accountable to the people affected by their decisions.

Governments are ill-suited to be managers. Arguably, their expertise does not lie in the managerial arena. More importantly, however, there is no effective way to hold them accountable for the multitude of management decisions required in health care. Rather, governments need only answer to themselves, and periodically to the ballot box. When the roles of governor and manager are conflated, there is no independent oversight of management decisions.¹²

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12. See Colleen M. Flood, *International Health Care Reform: A legal, economic and political analysis* (London: Routledge, 2000).

Nevertheless, provincial governments too often try to “micro-manage their health care systems,”¹³ in addition to (and sometimes instead of) governing them. Placing governance and management responsibilities in a single body creates a clear conflict of interest, with the result that neither function is performed adequately. Governments should “row less and steer more.”¹⁴

(iii) Accountability

Accountability, which applies both to governors and managers, includes evaluating how well or poorly the organization’s actions achieve desired and measured outcomes in the short-term and long-term. It requires explanations for the discharge of responsibilities entrusted to individuals or organizations: it is the justification of conduct.¹⁵ The concept of accountability, however, has expanded beyond the core idea of being called to account for decisions or actions. In the context of government, it is associated “with the broader notion of responsiveness to public concerns,”¹⁶ and it describes the level of such responsiveness.¹⁷ One way to understand the relationship between government and citizens is through agency theory, with citizens acting as principals and the government as their agent. “Agency costs arise whenever one person or organization [the principal] contracts with another person or organization [the agent] to perform a service, and the performance of

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13. Institute for Research on Public Policy, *IRPP Task Force on Health Policy: Recommendations to First Ministers* (Montreal: Institute for Research on Public Policy, 2000), online: Institute of Intergovernmental Relations <http://www.iigr.ca/pdf/documents/753_IRPP_Task_Force_on_Health.pdf> at 19.

14. *World Health Report 2000*, *supra* note 10; Richard B. Saltman, Joseph Figueras & Constantino Sakellarides, eds., *Critical Challenges for Health Care Reform in Europe* (Buckingham, U.K.: Open University Press, 1998).

15. K.J. Woods, “A Critical Appraisal of Accountability Structures in Integrated Health Care Systems” (Paper prepared for the Scottish Executive Health Department Review of Management and Decision Making in NHS Scotland, September 2002), online: Scotland’s health on the web <<http://www.show.scot.nhs.uk/sehd/publications/DC20021001CritApprAccount.pdf>> at 4.

16. *Ibid.* at 5.

17. John D. Donahue, *The Privatization Decision: Public Ends, Private Means* (New York: Basic Books, 1989) at 23.

this service necessitates the delegation of some decision making authority from the principal to the agent.”¹⁸ The agent’s interests are not identical to those of the principal,¹⁹ and agency costs represent the loss to the principal resulting from the agent’s failure to act as instructed, or in a manner that is not in the principal’s best interests.

Factors reducing agency costs between shareholders and managers in private companies are not generally present in the public sector.²⁰ Consequently, public sector agency problems are a great deal more complicated than in private firms. The burden of any inefficiency is diffused over the many individuals who make up the population served. Citizens at large have little incentive to band together into powerful lobby groups to counteract agency costs, because each individual’s share of the public sector’s inefficiency is very small. Individuals may also decline to lobby for improvement, in the expectation of a free ride upon the efforts of others.²¹ In contrast, members of interest groups with much to gain personally from a particular government decision have a greater incentive to lobby the government for policy changes that may not reflect the more diffuse interest of the public at large.

Transparency is the key to minimizing agency costs in the public sector. The more clear and open the lines of responsibility and accountability, the less risk there is that stakeholder interests will prevail over more diffuse public interests. Moreover, the greater the extent to which decisions can be devolved to decision-makers who are at arm’s length from the political process, the more likely it is that those decisions will be made on a principled or objective basis. In the health care sector, governments must be accountable both to citizens and to

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18. Michael J. Trebilcock, *The Prospects for Reinventing Government* (Toronto: C.D. Howe Institute, 1994) at 8.

19. Michael Jensen & William Meckling, “Theory of the Firm: Managerial Behaviour, Agency Costs, and Ownership Structure” (1976) 3 *Journal of Financial Economics* 305, cited in *ibid.*; Michael Jensen & Clifford Smith, “Stockholder, Manager, and Creditor Interests: Applications of Agency Theory” in Edward Altman & Martin Subrahmanyam, eds., *Recent Advances in Corporate Finance* (Homewood, Ill.: Richard D. Irwin, 1985) at 38.

20. Eugene F. Fama, “Agency problems and the theory of the firm” (1980) 88 *Journal of Political Economy* 288 at 291-293.

21. Donahue, *supra* note 17.

patients for the effectiveness of their leadership, especially with respect to long-term progress toward the realization of an articulated vision and set of values. Managers, by contrast, must be accountable for achieving the goals set for them by governors in their respective areas of responsibility in a manner congruent with the expectations and needs of the citizens they serve. They must be simultaneously accountable upstream, to those who govern, for realizing government's overall objectives, and they must also be accountable downstream to the citizens they serve for how they use their discretion in achieving government's larger objectives. The important question is whether a health care system contains adequate mechanisms to hold both governors and managers accountable for their respective decisions and actions. As noted above, accountability for governance occurs through the electoral process. This mechanism may not be perfect, due among other things to the role of interest groups in influencing decision-making, but it remains the best means to ensure accountability for the governance function. In many health care systems, however, there is little or no accountability for the management function.

We do not naively suggest that reforms directed toward clarifying the governance and management functions can occur overnight. We are acutely aware of the importance of legitimacy, an issue we will deal with in more detail below. Although governments may devolve managerial authority to arm's-length bodies, the public may continue to hold the government accountable for anything that happens in health care. It is vitally important that any devolved decision-maker have both real authority and legitimacy in the eyes of the public. Without credibility, a devolved decision-maker may simply be seen as the government's lap-dog.

II: Governance and Accountability in Ontario's Health Care System

A. Dual Governance in Canada's Federal Structure

Due to Canada's federal structure, the governance and management of health care, as well as the accountability for both, differ significantly from the health care systems in unitary states with which Canada is

usually compared, including New Zealand and the United Kingdom. The Canadian federal structure also differs from that in Australia, where there is a clearer division of constitutional responsibilities for the health care sector between the Commonwealth government (for physician services and for pharmaceuticals) and the states (for hospitals, community care and so on).²²

The Canadian Constitution²³ does not address health or health care as a single subject. However, judicial interpretation of the specific and general powers of the federal government and the provinces under the Constitution has resulted in the designation of health insurance and delivery of health care as provincial responsibilities.²⁴ Nonetheless, the federal government indirectly plays an important role. Through its spending and taxation powers, it raises funds and transfers them to provincial and territorial governments to support the provision of health services to their populations. The Federal government uses its spending power through the CHA to induce provinces to comply with five criteria in administering their publicly funded health insurance programs: universality, accessibility, portability, comprehensiveness and non-profit administration.²⁵ The most powerful provisions of the CHA, however, are those that prohibit any form of private financing for “medically necessary” hospital services and “medically required”

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22. See generally Colleen M. Flood, “The Prospects for a National Pharmacare Plan: Lessons from Australia” (Presentation to the Institute for Research in Public Policy, “National Aspects of Pharmacare”, September 2002), online: Institute for Research on Public Policy <<http://www.irpp.org/indexe.htm>>.

23. *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

24. See Colleen M. Flood, “The Anatomy of Medicare” in Jocelyn Downie, Timothy Caulfield & Colleen M. Flood, *Canadian Health Law and Policy*, 2d ed. (Toronto: Butterworths, 2002).

25. For a discussion of the *Canada Health Act* and the five criteria, see Colleen M. Flood & Sujit Choudhry, *Strengthening the Foundations: Modernizing the Canada Health Act* (Saskatoon: Commission on the Future of Health Care in Canada, 2002), online: Health Canada <http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/13_Flood_E.pdf>. Also available in Tom McIntosh, Pierre-Gerlier Forest & Gregory P. Marchildon, eds., *The Governance of Health Care in Canada: Selected Papers from The Commission on the Future of Health Care in Canada*, vol. 3 (Toronto: University of Toronto Press, 2004) at 346.

physician services. Indeed, as a result of this provision, a number of provinces prohibit the sale of private insurance covering such services.²⁶

Consequently, the thirteen provincial and territorial governments are responsible and accountable for the governance and management of the majority of health care services. At the same time, the federal government is responsible (and should be accountable) for governing the system nationally, ensuring that the values of universality, portability, accessibility, comprehensiveness, public administration and mandatory public financing for hospital and physician services are achieved, more or less equitably, from coast to coast. The federal government does this primarily by upholding and enforcing, through the threat of withholding transfers, the principles encapsulated in the CHA.²⁷ In short, the federal government assumes responsibility for maintaining the vision of Medicare cherished by Canadians: a national health care system to which everyone has universal and equitable access. As a result, both senior levels of government currently share the role of governing Canada's health care system.

The sharing of governance in Canadian health care, however, is not a case of "more is better." All systems struggle with decision-makers who are influenced by the interests of providers and other stakeholders at the expense of the larger public interest.²⁸ This problem is exacerbated in Canada by the fact that the two senior levels of government share responsibility for health care. Counterintuitively, such sharing has led not to stronger governance, but to a virtual absence of both governance and effective accountability for the system's performance, both nationally and provincially. Deficiencies of leadership and accountability featured prominently in the two most recent

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26. Colleen M. Flood & Tom Archibald, "The Illegality of Private Health Care in Canada" (2001) 164 Can. Med. Assoc. J. 826.

27. For a discussion of the extent to which the federal government enforces the Act, see Canada, Office of the Auditor General, "Federal Support of Health Care Delivery" in *Report of the Auditor General of Canada to the House of Commons* (Ottawa: Auditor General's Office, 1999) at 29:1-29:30.

28. Robert G. Evans, "Going for the Gold: The Redistributive Agenda behind Market-based Health Care Reform" (1997) 22:2 J. Health Pol. 427.

comprehensive reports on health care in Canada, *Building on Values*²⁹ (the Romanow Report) and *The Health of Canadians—The Federal Role*³⁰ (the Kirby Committee Report). Both reports deal extensively with what Romanow refers to as the “jurisdictional or funding issues that have been the focus of intergovernmental debate for much of the past decade.”³¹ Provinces claim that problems in the system are rooted in under-funding on the part of the federal government. The federal government periodically negotiates funding arrangements with the provinces, but no changes to the structural status quo are made. As a result, the cycle of protest and appeasement proceeds unabated. The sideshow of federal-provincial bickering over funding and the ensuing media frenzy distracts attention from the yawning gaps in governance, management and accountability, which continue to be ignored.

Long-standing wrangling between the federal and provincial governments over shares of health care financing has clouded the key issue of accountability: who is accountable for what? This problem extends well beyond the jurisdictions of the two senior levels of government. It has become an example of what is colloquially referred to as the “field of silos.”³² The silos represent the many institutions, organizations and individuals that are cobbled together to constitute the health care system. In contrast to the private sector, where accountability clearly and legally rests with a corporation’s board, publicly administered health care does not have a board of directors. In Ontario, final responsibility for hospitals is split between the hospital boards and the Ministry of Health and Long-Term Care, with the

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29. Canada, Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada* (Ottawa: Canada Communication Group, 2002) c. 2 (Commissioner: Roy Romanow) [Romanow Report].

30. Kirby Report, *supra* note 5.

31. Romanow Report, *supra* note 29 at 53.

32. Canada, Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians—The Federal Role*, vol. 4 (Ottawa: Canada Communication Group, 2001), online: Parliament of Canada <<http://www.parl.gc.ca/37/1/parlbus/commbus/senate/com-e/soci-e/rep-e/repintsep01part3-e.htm>> c. 8.2.3 (Chair: The Honourable Michael J.L. Kirby, Deputy-chair: The Honourable Marjory LeBreton). This report refers to the silos of financing for health care and how regionalization can assist to break down those silos.

Ontario Hospital Association's collective functions somewhere in the mix.³³ In other parts of the Ontario system (physicians' offices for example) no policy-making body comparable to a board of directors exists. As we explain more fully below, accountability is diffused (and confused) among the various decision-makers that collectively and haphazardly run Ontario health care.

In Ontario and across Canada, health care is often portrayed as being in crisis, as manifested in packed emergency rooms, growing waiting lists, increased public concern about the quality and timeliness of care, increased litigation and continued complaints from governments about the level of public resources required to sustain the system and meet growing expectations. Physicians, nurses, hospitals and other providers use "crisis talk" when seeking greater funding from provincial governments. In turn, provincial governments use crisis talk when seeking greater funding from the federal government. Such talk also makes for scintillating front-page headlines and is thus extremely popular with the media. In the end, recurrent political debates are reduced to issues of money, and the problems of the system are blamed on the lack of it. We believe, however, that the Ontario crisis in health care, along with similarly situated health care schemes, has more to do with an absence of effective governance. No entity is clearly responsible either for governing the system or for managing it.

B. The Legal Framework for Governance in Ontario

A recent review of the legal framework for governance in Ontario reveals at least 24 pieces of legislation affecting the role and accountability of each of five key decision-makers in the health care

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

system.³⁴ These decision-makers are the Minister of Health; the Ministry of Health; public hospital boards; Community Care Access Centres (CCACs) that purchase home care services; and physicians, whose decisions on treatment and referral are key factors in determining total cost and utilization of the system. The legislation reveals a mishmash of overlapping responsibilities, with little attention paid to articulating spheres of responsibility or to identifying areas of competency, lines of accountability, and incentives for performance. The poor state of legislation for the governance of health care reflects the underlying problem of poorly assigned governance and managerial roles. Good governance requires good legislation, but historically, Ontario provincial governments have been too busy micro-managing the system to be very concerned about governing it.

One important statute, the *Health Insurance Act*,³⁵ validates and underscores the vision of publicly funded Medicare as a simple insurance program. In the 1960s, when the foundations of Medicare were laid, it was thought that governments would act as private indemnity insurers, reimbursing physicians, hospitals and other institutions for any and all services provided.³⁶ It was assumed that no service would be provided that was not “medically necessary.” This vision of Medicare is clearly outdated. In both public and private health spheres, there has been a radical shift in the concept of the health insurer/payer, due to concerns

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34. Jennifer Martin & Colleen M. Flood, *The Legal Framework for Health Governance in Ontario* (Background Paper No. 1 for the Defining the Medicare Basket Project, October 2003) [unpublished, archived online: Defining the Medicare Basket <http://www.law.utoronto.ca/healthlaw/basket/docs/background1_legalframework_ont.pdf>].

35. R.S.O. 1990, c. H.6.

36. For a discussion of the “accommodation” struck between the government and the medical profession at the inception of Medicare, see Carolyn Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain and Canada* (New York: Oxford University Press, 1999) at 50-56. “The ‘Medicare pact’ that accompanied the introduction of national health insurance in Canada is essentially that government pays the bills and leaves those in medicine to practise their profession.” Jonathan Lomas, “Devolving authority for health care in Canada’s provinces: 4. Emerging issues and prospects” (1997) 156(6) Can. Med. Assoc. J. 817 at 818, online: Canadian Medical Association Journal <<http://www.cmaj.ca/cgi/reprint/156/6/817>>.

about moral hazard and rising costs.³⁷ In the private sector, insurers/payers are actively intervening, structuring, monitoring and even managing the care that physicians and others provide to patients. These activities are sometimes described as managed care initiatives.³⁸ The focus is on both the funding and delivery of services. In the public sphere, most attention is paid to the level of resources invested in the system, although it is understood that increased spending is not necessarily related to improvements in health. In both the public and private spheres, therefore, the insurer is (or should be) more than simply a payer for care. It is extremely hard to dislodge the myth that government should act as mere insurer, funding any care that a physician thinks necessary. This is likely in part due to the interests of providers and some patients in perpetuating the myth. The legislative framework in Ontario must change to reflect the paradigm shift in the understanding of contemporary Medicare.³⁹

III: The Case for Devolution: Closing Health Care Gaps in Both Theory and Practice

Devolution to subsidiary agencies is not a new idea. It has been popular in policy circles worldwide for many decades. As early as 1964, the Canadian Hall Commission identified regionalization of responsibility for health care services as a good idea.⁴⁰ More recently, in

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37. For a discussion of various reform initiatives in the Netherlands, the U.K., the U.S. and New Zealand, see Flood, *supra* note 12, c. 2.

38. *Ibid.*

39. *Ibid.* A recent review of the regionalization experience in Canada reflects that “many health reform goals require nothing less than a transformation of how society views health, and in the culture of healthcare delivery.” See Steven Lewis & Denis Kouri, “Regionalization: Making Sense of the Canadian Experience” (2004) 5:1 *Healthcare Papers* 13. We agree, but we believe that the law can assist in shaping views in society and that a change in the law can, over time, have a profound effect on social values.

40. Canada, Royal Commission on Health Services, *Report of the Royal Commission on Health Services*, vols. 1, 2 (Ottawa: Queen’s Printer, 1964-1965).

1993, the Premier's Council on Health, Well-Being and Social Justice⁴¹ reviewed various models of devolution and decentralization. However, Ontario has never implemented any comprehensive form of devolution. The province remains, in effect, Canada's control group in the devolution movement. Alongside theoretical investigation and endorsement, there is substantial experience with devolution and regionalization of responsibility for health care services internationally and in other Canadian provinces. These experiences stand as teaching models for the reform of Ontario's system.

A. Advantages of Devolution

Devolution can be defined broadly as the transfer of power and authority to regional authorities or other bodies that are largely at arm's-length from government. The first and most often cited advantage is the shifting of decision-making closer to the community served, thereby providing greater opportunity for direct accountability.⁴² In contrast to a more distant central authority, regional authorities allow for those affected—patients, providers, and members of the general public, including prospective patients and taxpayers—to bring their views more easily to the attention of decision-makers, on specific issues such as local trade-offs between institutional care and community-based care. Citizens know where “the buck stops.” In this way, devolution increases the sense of ownership of those affected, both in decisions made and in their outcomes, especially when planning is done and implemented at a community or regional level.

Moreover, by empowering communities, devolved authority may serve to rationalize the local or regional health care system through finely tuned and community-sensitive approaches. Within centrally

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41. Ontario, Premier's Council on Health, Well-Being and Social Justice, Task Force on Devolution, *Devolution and Decentralization of Health Care Systems: A Review of Models* by Vandna Bhatia & Stephen Dibert (Toronto: Premier's Council on Health, Well-Being and Social Justice, 1993).

42. See Lewis & Kouri, *supra* note 39 at 16. For a discussion and critique of the notion of community empowerment through regionalization, see also Lomas, *supra* note 36 at 819.

determined limits of province-wide equity (a governance responsibility), the mix of health services and expenditures can be more closely tailored to meet identified local or regional needs. In a province as diverse as Ontario, this can diminish the “one size fits all” approach and can facilitate the evolution of different, more flexible organizational structures.⁴³

The second advantage offered by devolution, as discussed above in Part I.B, is not often mentioned in the relevant literature, and yet in our opinion it is the most important advantage of all. This is to shift accountability for managerial or operational decisions away from governments. A government should not make or be held accountable for the myriad of small but critical decisions in health care. Rather, it should be held accountable for governance decisions, such as ensuring that the bodies to which it has devolved managerial responsibility satisfy the particular needs of the people they serve.

With respect to this latter governmental function, devolution helps to install a series of checks and balances. Government should monitor the performance of subsidiary agencies that manage the health care system, rather than attempt to fulfill simultaneously the conflicting roles of regulator, manager and purchaser. The current health care system in Ontario is most weakened by its failure to hold the managers of the system accountable. As Donahue notes, an essential component of accountability is that those who hold a body to account stand themselves outside that body.⁴⁴ By devolving the management function to a separate organization, government can monitor the performance of arm’s-length management agencies. Splitting the governance and management functions will never completely resolve the conflict of interest problem, for it requires governors to oversee and check the performance of managers. However, it will clarify roles and lines of responsibility, thus lessening the prospect that short-term political interests will dominate decision-making.

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43. For example, regional health authorities, organized for a geographically defined region, may not be well-suited for large cities, where competing integrated health systems may work better. See discussion on inter-regional transfers, below at Part III.B.(ii).

44. *Supra* note 17.

If this advantage is to be realized, proper monitoring mechanisms must be instituted. A lesson emerging from the experience with internal market reform in both the U.K. and New Zealand was the importance of monitoring all aspects of performance, and not just those that are easy to measure.⁴⁵ It is tempting to focus on easily measured objectives, such as increased turnover or reduced waiting lists, and to ignore or postpone the development of methods that measure important but more elusive indicators, such as the outcomes of hospital-patient or physician-patient interactions. To avoid skewing a system toward those indicators that can be measured easily, it is vital to ensure the development of the more abstract and broader measures of performance, such as user satisfaction with the health care system or the quality of services delivered.⁴⁶

Governments should develop sensitive measures that evaluate health care outcomes, quality of services (including patient satisfaction) and accessibility (including waiting times). Moreover, provincial governments should develop financial and other incentives, such as public recognition, to engage devolved decision-makers in the development and use of such measures. This is essential if we are to move past the present impasse, where nothing changes despite evidence of variations in clinical practice that cannot plausibly be defended. Without evidence of the link between health care services and outcomes, it is difficult, particularly given the strong faith of the general public in clinical decision-making, to focus the discussion away from access and money and onto the real problem: the quality of care delivered.⁴⁷

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45. See Flood, *supra* note 12, c. 4; Janet Mclean & Toni Ashton, "Quasi-markets and Pseudo-contracts in the New Zealand Public Health System" (2001) 10:1 Otago L. Rev. 17; Pauline Allen, "Contracts in the National Health Service Internal Market" (1995) 58:3 Mod. L. Rev. 321 at 339.

46. For a discussion of performance reporting and accountability, see generally Centre for Health Services and Policy Research, "What a tangled web we weave: Improving performance reporting and accountability in BC" (Proceedings from the 16th annual health policy conference of the Centre for Health Services and Policy Research, 7 November 2003, Vancouver, B.C.) at 5 [unpublished].

47. We are grateful to Steven Lewis for this point.

Third, devolution can correct the problem of funding silos, which has long bedevilled health care in Canada.⁴⁸ Keeping separate streams of funding for acute care hospitals, physician compensation, home care services, mental health services and other institutions and organizations makes sense only when these contributors function independently and regard one another as competitors for shares of funding, rather than as collaborators in achieving high standards of performance. In a genuine co-operative system, it makes no sense.

Currently, decision-makers appear to have neither the motivation nor the capacity to make rational decisions about deploying resources from one silo to another. In theory, it is possible for the Ontario Ministry of Health and Long Term Care to break down silos and shift resources, but in reality it is almost impossible. Decision-makers within the Ministry, mired in a web of relationships with different interest groups, find it extremely difficult to change long-held political accommodations. By using community empowerment, it is hoped that governments can establish an alternative source of legitimate power over dominant interests that have historically prevailed.⁴⁹

Therefore, under devolution, citizens could serve as agents of rationalization, integration and coordination, allocation of scarce resources and “taming” of powerful interest groups.⁵⁰ Regional or local authorities can be less susceptible to overt political pressure from powerful interests, and would be more likely to lead to rational, evidence-based decision-making. Devolving fiscal responsibility to regional authorities or other bodies thus provides an opportunity to merge pre-existing silos of funding into the hands of one decision-maker empowered to allocate resources rationally across a variety of health care needs. The several players would become members of the same team, all concerned with using their allocated budgets to provide patients and their families with a smooth continuity of high quality, compassionate care. Incentives that presently encourage acute care hospitals to solve their financial problems by discharging patients too early to nursing homes, to home care or to unpaid family care-givers

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48. Romanow Report, *supra* note 29 at xviii-xix.

49. Lomas, *supra* note 36 at 819.

50. *Ibid.*

would be eliminated. Family physicians would not feel compelled to refer time-consuming patients to specialists or those seeking out-of-hours service to hospital emergency rooms.

Integration of funding for a broad range of health care services also constitutes an important aspect of accountability. It ensures that the responsible manager makes efficient substitution decisions among different services. Although integration cannot eliminate arguments over the adequacy of the overall funding provided, the integration of funding forces substitution decisions to be made at the only level where the information necessary to make good decisions is available—on the ground, as close as possible to the providers and consumers affected by the decisions.⁵¹

A final advantage offered by devolution, and one of the most attractive benefits for governments, is the prospect of depoliticizing difficult rationing and prioritization decisions inherent in the provision of health care.⁵² This claim, however, will likely be met with scepticism in Ontario, given the province's experience with devolution to Community Care Access Centres (CCACs). These arm's-length organizations were created by the Conservative government of the day to fund and purchase home care services from competing providers.⁵³ The government provided no framework for coordination between CCACs and the hospitals, whose discharged patients increased the demand for home and long-term care.⁵⁴ Nor could the CCACs control the rates of pay for the service providers.⁵⁵ Moreover, the government

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51. *Ibid.*

52. *Ibid.*

53. For a brief review of all the functions of Community Care Access Centres, see Jonathan Gray, "Home Care in Ontario: The Case for Co-payments" (2000) 8 Health L.J. 177.

54. *Ibid.* at 181. For more on the difficulties of accessing acute home care services following hospital discharge, see Peter C. Coyte & Wendy Young, "Regional Variations in the use of home care services in Ontario 1993/1995" (1999) 161:4 Can. Med. Assoc. J. at 376.

55. CCACs award contracts by issuing requests for proposals (RFPs). Contracts must be awarded on the basis of a highest quality/best price formula, over which the CCACs have no control. See Melanie Harju & Christel A. Woodward, "Indicators of Consistency of Homecare Providers under Managed Competition: A Case Report from Ontario"

handicapped CCACs from the very beginning of their tenure, by coupling their creation with major spending cuts.⁵⁶ They were expected to be accountable, and simultaneously to balance competing pressures from the provincial government, providers and local citizens. This was an impossible mandate, given the limits of their budgets and authority. When the CCACs were unable to satisfy community demand, they blamed reduced service levels on the provincial government's refusal to provide requested additional funding.⁵⁷ In response, the provincial government re-centralized many of the previously devolved management responsibilities.⁵⁸

Despite the outcome, this experience should not be viewed as conclusive evidence of a peril of devolution. Ontario's experience with CCACs was not a product of devolution per se; rather, the negative outcome was due to "lip service" devolution. Without a legislative framework for their authority, neither the CCACs nor the communities they served ever regarded themselves as genuinely independent decision-makers acting within a policy framework set by government. CCACs thus did not have the requisite legitimacy that would persuade the public that they should not pierce the veil of devolution and hold the government directly to account. Furthermore, CCACs did not have adequate funding or control over expenses to meet service expectations. This resulted in a misalignment of mandate, accountability and budget—

(Spring 2003) Health Care Management Forum, online: Canadian College of Health Service Executives <<http://www.cchse.org/Forum/Spring2003/Harju%20final.pdf>>.

56. For a review of the fiscal climate surrounding the launch of CCACs see Charlotte Gray, "Will Voters' Response to Health Care Reform Determine the fate of Mike Harris?" (1999) 160:11 Can. Med. Assoc. J. 1623.

57. Ontario Health Coalition, *Dip and Skip: Supplement to the June 2001 Report on Home Care Reform in Ontario* (Toronto: Ontario Health Coalition, 2001).

58. The effect of the *Community Care Access Corporations Act*, S.O. 2001, c. 33 has arguably been to reverse many of the underlying policies of decentralization represented by the CCACs; that is, it subjects a great deal of the decision making to ministerial discretion, thus undermining the capacity of CCACs to take responsive, locally based decisions. See also Miller Thomson LLP, *Bill 130: Community Care Access Corporations Act, 2001* (Communiqué for Health Industry Clients on the Legal Retainer Program) (16 November 2001), online: Miller Thompson LLP <http://www.millerthomson.ca/pdf/comm_community_care.pdf>.

a process Steven Lewis refers to as “asynchronous devolution.”⁵⁹ In light of these problems, the CCAC experience does not argue against devolution. Rather, it provides an example of what not to do when devolving responsibility in health care.

As demonstrated by school boards, municipalities, children’s aid societies, public health authorities and other subsidiary bodies, local entities can diminish and diffuse the partisan political implications of managerial or operational decisions if they are not hampered by structural constraints. Once the functions of devolved authorities such as RHAs have been defined, it is imperative that the government give them the authority and funding necessary to perform their functions effectively. No Canadian province, however, has given to RHAs the funding to manage the full range of services that are actually delivered in their respective regions. In no province, for example, do RHAs negotiate the rates of compensation for health professionals, nor do they have any say on what prescription drugs are publicly funded.⁶⁰ Agency theory suggests that if the transfer of responsibility to agents is not accompanied by the power to control outcomes, dysfunctional behaviour will result.⁶¹ Without devolution of the whole range of authority needed to complete their designated tasks, RHAs will merely add their voices to local discontent with fiscal retrenchment.⁶² Together with the media and citizens, they will shift political blame centrally to Ministers of Health and the government.

Trust and partnership between governments and the agencies to which they devolve managerial responsibilities must be fostered if devolved authorities are to deflect unwarranted blame from provincial governments. These authorities will contain conflict only while they believe that there is still slack in the system, that efficiency can be improved, and that they have control of all the “levers” necessary to contain their expenditures.

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59. Personal communication.

60. This particular problem was noted early on in the regionalization process by Jonathan Lomas, *supra* note 36 at 820.

61. Eugene F. Fama, “Agency Problems and the Theory of the Firm” (1980) 88 *Journal of Political Economy* 288.

62. *Ibid.*

B. Disadvantages of Devolution

Critics mention several disadvantages of devolving managerial authority from provincial ministries to arm's-length regional authorities. Some are real and some are of little or no consequence. Governments often cite these shortcomings when re-centralizing authority or explaining their refusal to adopt devolution. We set out these concerns below, identifying those we consider to be genuine and exploring some measures to compensate for them.

(i) Extra Administrative Costs

It is often argued that devolution will result in an additional layer of bureaucracy and higher administrative costs.⁶³ This is true, unless government ministries are themselves restructured or downsized to accommodate the devolution of service delivery management. While the existing bureaucracy is certainly unwilling to downsize,⁶⁴ the experience of devolution in Canada suggests that there has been no net increase in administrative costs. This is because devolution of managerial responsibilities to RHAs has been accompanied in many provinces by a significant centralization of managerial responsibilities through the

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63. For a discussion of some of the potential obstacles in the practical implementation of decentralized decision-making see Jeremiah Hurley, Stephen Birch & John Eyles, "Geographically-decentralized Planning and Management in Health Care: Some Informational Issues and their Implications for Efficiency" (1995) 41 Soc. Sci. Med. 6.

64. The recently elected Liberal government in Quebec announced plans "to eliminate regional boards and replace them with a less bureaucratic structure." "Dumont calls Landry proposal 'blackmail'" *The Globe and Mail* (online version) (8 April 2003), online: globeandmail.com <http://www.theglobeandmail.com/servlet/Page/document/v4/sub/MarketingPage?user_URL=http://www.theglobeandmail.com%2Fservlet%2Fstory%2FRTGAM.20030408.wqueb48%2FBNStory%2FNational&ord=1101257397056&brand=theglobeandmail&force_login=true>. See also Kevin Dougherty, "I'd slash taxes: Charest: Liberal leader unveils action plan that would focus on health, education" *The [Montreal] Gazette* (13 September 2002) A10. This approach is problematic, as it reflects the assumption that additional bureaucracy is necessarily bad. The Quebec government should instead have asked itself whether the benefits gained from devolution outweigh any additional administrative costs.

elimination of other authorities such as hospital boards.⁶⁵ In these circumstances, total administrative costs may not increase at all. In any event, the right question to ask is not whether administrative costs will increase, but whether the benefits of devolution/regionalization will outweigh its costs.

(ii) Inter-regional Transfers

A second (and substantive) disadvantage associated with devolution relates to the relationships between provincial governments and regions, as well as relationships among regions. Governments are concerned about diminution of their ability to co-ordinate centrally the provision of services.⁶⁶ Institutions that now provide highly specialized services province-wide (or even nation-wide), such as organ transplants or sophisticated pediatric services, are situated in a particular region but can only be properly funded and governed centrally. Centralized decision-making is necessary to ensure that individuals from regions without such services can gain equitable access to them. Even when authority is devolved, it is well-recognized that there must be a capacity for central direction in particular cases when inter-regional co-ordination is essential, such as purchasing expensive equipment and providing services like radiation therapy or open-heart surgery. This notion is reflected in Ontario in such inter-regional agencies as Cancer Care Ontario and the Cardiac Care Network, which carry partially

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65. There are exceptions. Hospital boards have not been eliminated in Quebec, for example, and in Alberta the boards of Catholic hospitals continue in place. For a brief discussion of the history of faith-based institutions in Canada, see "CHAC opposes call for ban on religious hospitals" (Ottawa: Catholic Health Association of Canada, 5 December 2002), online: Catholic Health Association of Canada <<http://www.chac.ca/newsrelease/current/morgentaler.pdf>>.

66. For a discussion of the recentralization that has occurred in a number of European countries, see Vaida Bankauskaite, Richard B. Saltman & Karsten Vrangbaek, "The Role of Decentralization of European Health Care Systems" (Report presented to the Institute for Public Policy Research, U.K., February 2004), on-line: Institute for Public Policy Research <<http://www.ippr.org.uk/research/files/team40/project230/Decentralisinghealthservicesinothercountries.pdf>>.

devolved system-wide responsibilities.⁶⁷ To further the effectiveness of these agencies, RHAs can collectively assign to them the responsibility for coordinating the management of the relatively few, highly sophisticated, resource-intensive services better dealt with centrally. Moreover, RHAs will seek to co-ordinate such activities in pursuit of their own self-interest, if not in pursuit of the larger public interest.

Another problem of devolution is that good transportation systems may lead to difficulty in establishing effective regional boundaries in highly populated areas. People can and will shop from region to region in search of services to which a particular region has given priority. This complicates inter-regional transfers of funds, but to date, the experience in all provinces with RHAs suggests that it is possible to provide for funding transfers for inter-regional services.⁶⁸ Moreover, this complexity may be advantageous if reform seeks to encourage competition among integrated health systems, as is discussed below.

A concern particular to Ontario is that the dominance of Toronto, both in population and in the delivery of acute and tertiary services, means that devolution based on geographic boundaries is simply not feasible.⁶⁹ The complexities of Ontario's size and geography, however, do not preclude a devolved system. Other large metropolitan areas within Canada have been incorporated into regions. Metropolitan

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67. For example, Cancer Care Ontario (CCO), a provincial statutory corporation created in 1997, has a mandate to coordinate cancer services in Ontario, including surveillance programs, screening procedures, systematic chemotherapy, and new and expensive pharmaceutical treatments. Through its mandate, and with a budget approximating 23% of traceable costs in the province's cancer system, the CCO's practices and policies have a significant impact on the management and coordination of Ontario's cancer control strategy and management. For a discussion, see Terrence Sullivan *et al.*, eds., *Strengthening the Quality of Cancer Services in Ontario* (Ottawa: CHA Press, 2003).

68. See *e.g.* (2004) 5:1 HealthcarePapers, containing a collection of articles discussing devolution in Canada, in which this is not raised by any author as a particular problem.

69. For a discussion of the difficulties of drawing regional boundaries in Ontario, see Peggy Leatt & Beverley J. Nickoloff, *Managing Change: Implications of Current Health Reforms on the Hospital Sector* (Toronto: Ontario Hospital Association, 2001) at 53. For more general criticisms of the imposition of regional boundaries, see Ontario Hospitals Association, *Regional Health Authorities in Canada: Lessons for Ontario* (Toronto: Ontario Hospital Association, 2002) at 5.

Vancouver is split into two regions and Montreal into three. Edmonton and Calgary, each with populations of about one million people, are each served by one large regional health authority. Arrangements will obviously need to be made between regions, both within Toronto and across Ontario—coordinated centrally if necessary—to ensure equitable access for all residents of the province to centralized services located in Toronto. If geographic regional boundaries prove unworkable, a different management structure, such as competing integrated health systems, is available.

It is worthwhile to pause here to consider what other possibilities there are for devolution in the city of Toronto, given that it is so frequently cited by those opposed to devolution in Ontario. Devolution is possible through a different form of management structure that eclipses geographic boundaries—integrated health systems (IHSs). An IHS is:

a network of organizations . . . which provides, or arranges to provide, a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally responsible for the health status of that population.⁷⁰

Under this model, a decentralized body at arm's length from government (for example, a network of hospitals, family doctors and nurses, CCACs and long-term care facilities) manages the delivery of a comprehensive array of services, including health promotion, primary care, diagnostic treatment, rehabilitation and long-term care services. Patients enroll in the system through multiple points of access, and flow seamlessly to the most clinically and economically appropriate locus of care.⁷¹ Common ownership of provider organizations is not necessary, although it may help reduce transaction costs. Rather, integration is achieved “virtually,” through inter-organizational arrangements such as

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70. Kelly J. Devers *et al.*, “Implementing organized delivery systems: an integration scorecard” (1994) 19:3 Health Care Management Review 7 at 8.

71. Jeffrey A. Alexander, Howard S. Zuckerman & Dennis D. Pointer, “The challenges of governing integrated health care systems” (1995) 20:4 Health Care Management Review 69 at 70.

strategic alliances, joint ventures and contracts.⁷² Virtual health care systems invest substantial resources in developing and maintaining their provider networks, focusing primarily on a community-based network of primary care physicians, nurses, and other providers.⁷³ Primary health care thus becomes the backbone of an IHS, and the focus of health care is moved from acute facilities into community settings. With or without physical integration, a well-developed information system is crucial for the provision of timely, accurate and comprehensive information about costs, quality, use, workload, outcomes and satisfaction,⁷⁴ in order to integrate effectively managerial, governance, information, and financial mechanisms as well as clinical services. Integration is thus understood as an economic and operative concept within which various components of the health care delivery system have the same interests and objectives.⁷⁵

Services under an IHS are provided to a roster of individuals and families who contract with the system for care.⁷⁶ The population served is therefore not defined by geography, but by the registration or enrolment of individuals and families. Practitioners are provided with a base income dependent on the number of enrollees, so a practitioner has no incentive to provide services or referrals that are not medically necessary. The system is funded on weighted capitation payments, meaning that each IHS receives public funding on a per-enrollee basis, adjusted according to the patient's sex, age, health status, previous use and other factors.⁷⁷ This funding pays for all insured health services

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72. Jeff C. Goldsmith, "The Illusive Logic of Integration" (1994) 37:5 *Healthcare Forum J.* 26.

73. *Ibid.* at 29-30, cited in Peggy Leatt, George H. Pink & Michael Guerriere, "Towards a Canadian Model of Integrated Healthcare" (2000) 1:2 *HealthcarePapers* 13 at 23.

74. Peggy Leatt, George H. Pink & David Naylor, "Integrated Delivery Systems: Has Their Time Come in Canada?" (1996) 154:6 *Can. Med. Assoc. J.* 803 at 804.

75. James A. Rice *et al.*, "Capitation and Integrated Health Care Systems" (1996) 14:2 *Journal of Health Administration Education* 205.

76. For a general discussion see John Marriott & Ann L. Mable, "Integrated Health Organizations in Canada: Developing the Ideal Model" (2000) 1:2 *HealthcarePapers* 76. For a discussion of integrated health systems (described in terms of managed competition) see Flood, *supra* note 12, c. 1, Conclusion.

77. W. Young *et al.*, *Beyond Demand: the Case for a Needs-Based Approach to Health Systems Funding* (Toronto: Institute for Clinical Evaluative Sciences in Ontario, 1995).

required by the enrollee for a set length of time. It represents a cash flow to the system and does not define funding for any particular provision of care.⁷⁸ Capitation funding has been criticized on the ground that it provides an incentive for the under-provision of services.⁷⁹ However, the operative features of the HIS—consumer choice and system competition—are specifically designed to limit this risk.

As information systems improve (and better information becomes available about the nexus between health care services and health outcomes), it may be possible to enable citizens to choose between competing IHSs, and to “exit” a given IHS when their health needs are not being met⁸⁰—in other words, to vote with their feet. To foster the exit option, an information system designed to collect, track and report health service access, quality and outcomes must be available to patients. In this way, patients will be educated about their health and health care options in the hope that they will act as coordinators of their own care. Because capitation funding follows the patient, any cost savings for providers that are obtained at the expense of outcomes, quality or client satisfaction will result in patient withdrawal and enrolment in another system. This would threaten the revenue base of the original IHS.⁸¹ As a consequence, the rate of integration accelerates within environments where there is strong competition for IHS enrollees. In light of all of the above, integration is understood as an economic and operative concept within which various components of the health care delivery system have the same interests and objectives.⁸²

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78. Marriott & Mable, *supra* note 76 at 83.

79. For a general discussion see David Orentlicher, “Paying Physicians More to Do Less: Financial Incentives to Limit Care” (1996) 30 U. Rich. L. Rev. 155.

80. See Flood, *supra* note 12.

81. *Ibid.* at 806.

82. Rice, *supra* note 75. In practice, there are many difficulties and problems with operating competition between IHSs. Among them is the question of how to risk-adjust the payments that competing IHSs receive, so that they are not rewarded for avoiding high-risk patients. See Flood, *supra* note 12.

(iii) Loss of Monopsony Purchasing Power

A further disadvantage of devolution is a loss of monopsony⁸³ purchasing power. Governments are concerned about losing the bargaining power that results from being a single large buyer of health care. However, there are many actions that could be taken to allow for devolution while still reaping the benefits that come from being a single or large purchaser of health care. For example, RHAs could form joint purchasing agreements or associations, or for certain services the provincial government could continue to be the central bargaining agent (for example, in negotiating prices with multinational drug companies).

(iv) Devolution of Misery

A fourth disadvantage associated with devolution is the worry that government will download responsibilities along with unrealistic budgets and unrealistic public expectations.⁸⁴ Governments may value

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83. "In economics, a monopsony is a market with only one buyer. This can be compared to a monopoly, in which there is only one seller," online: Fact-index.com <<http://www.fact-index.com/m/mo/monopsony.html>>. In the U.S., several studies have shown that large insurers are able to extract discounts from providers. See e.g. Frank A. Sloan & Edmund R. Becker, "Cross-subsidies And Payment For Hospital Care" (1984) 8:4 J. Health Pol. 660. In those countries where government expenditures account for the great majority of total health expenditures, governments have been able to use their monopsony purchasing power to control costs. See e.g. The Health Care Study Group, "Understanding The Choices in Health Care Reform" (1994) 19:3 J. Health Pol. 499.

84. For the U.K. experience in this regard, see Mark Exworthy, "Primary Care in the UK: Understanding the Dynamics of Devolution" (2001) 9:5 Health and Social Care in the Community 266. For a detailed review of the concerns associated with selecting the appropriate powers to devolve in a Medicare, see Carolyn Tuohy, "Governance and Accountability in the Ontario Health Care Arena" (Paper presented to the Panel on the Role of Government, December 2003) [unpublished, archived online: <<http://www.law-lib.utoronto.ca/investing/reports/rp48.pdf>>]. See also David MacKinnon, "Transforming the Hospital Systems for the 21st Century" (Paper Submitted to the Senate Committee on Social Affairs, Science and Technology, 22 May 2002) [unpublished, archived online: <[http://www.oha.com/oha/reports.nsf/\(\\$Att\)/kdhi5aervg/\\$FILE/PresentationtoKirbyCommitteeonRHAFinal.pdf?OpenElement](http://www.oha.com/oha/reports.nsf/($Att)/kdhi5aervg/$FILE/PresentationtoKirbyCommitteeonRHAFinal.pdf?OpenElement)>] at 7. MacKinnon notes that an unstated goal of governments in pursuing regionalization is

devolution's capacity to depoliticize rationing and prioritization decisions, precisely because it allows government to avoid responsibility for decreases in health funding. Critics claim that governments seek to avoid the political costs of reducing health spending by devolving managerial responsibility and providing "envelope" funding.⁸⁵ Devolved authority will be blamed for poor management if there are growing waiting lists or other problems,⁸⁶ so it may lead to the political pathology of government avoiding accountability for difficult policy decisions.

The concern that governments will download misery rather than appropriately funded autonomy should not be understated. However, it is also true that governments may do everything correctly and still be held to account for bad management decisions made by devolved authorities. Even with generous global budgets and the flexibility to manage them, their own inefficient management may lead such authorities to run cap-in-hand to the government (or the media), claiming poverty and demanding increased funding.

Both of these risks can be ameliorated. Funding formulas and mechanisms for acceleration of funding must be fair, transparent, and sheltered from short-term political decision-making. The legitimacy of regional health authorities must also be fostered over time, so that both citizens and the media will come to understand the realignment of responsibilities between government and the devolved authority. Political backbone is required, for if a government backs down at the first ill-founded claim for funding by a devolved authority, the rules of the game will be set from then on. As with many problems in health care, the answer lies in the development of appropriate information systems to compare and contrast the success of different RHAs and IHSs in meeting the spectrum of health care needs of their citizens within the

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to "allow governments to distance themselves from major restructuring and tough choices."

85. See Jonathan Lomas's discussion of blame avoidance and conflict containment in *supra* note 36. For a general discussion of how restructuring government can be used as a means to defray the political costs of welfare reform, see Fiona Ross, "Beyond Left and Right: The New Partisan Politics of Welfare" (2000) 13:2 Governance 158.

86. This has long been recognized as a problem in the context of Aboriginal self-government.

limits of comparable budgets. Sharing such comparative information with the general public on a regular basis in the form of “report cards” would provide devolved authorities with strong incentives not to blame the government for their financial problems.

(v) Recruitment of Expertise

Related to the issue of ensuring legitimacy is the issue of expertise. It may be difficult to recruit employees with the expertise required for the effective management and local governance of a devolved health care system. As with District Health Councils, CCACs and school boards, finding known and respected leaders from the community to serve on the boards of RHAs can be difficult. The observed difficulties in recruiting expertise are directly linked to the structure of RHAs. No one with vision, experience and expertise will participate in, much less run, a lame-duck organization. The structure must give decision-makers real power and real responsibility, realistic mandates and budgets, strong financial and professional rewards, and public recognition for achieving clearly stated goals. Decision-makers do not want to be mere puppets of government. In Ontario, as in many jurisdictions, health care is the largest industry,⁸⁷ and like any industry, it needs talented management in order to succeed. However, there is a perception that public money is wasted on hiring talented managers. In addition, the public is understandably concerned that political cronies will be appointed to these well-paid public service jobs. However, transparency in the hiring process and regular public reporting requirements will ensure that citizens see that expenditures on management translate into real benefits.

(vi) Stakeholder Opposition

A final disadvantage associated with devolution is the strong political opposition it elicits from powerful interest groups in the health care

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87. In 2002 and 2003, Health and Social Assistance provided the largest source of job growth in the province. See Government of Ontario, *Opening Doors: Annual Labour Market Report* (Ontario: Ministry of Training, University and Colleges, 2003).

sector. In Ontario, for instance, hospital boards and physician associations oppose devolution.⁸⁸ Hospital boards fear a loss of management control. Physicians fear that the funding envelope for fees will also be devolved, and that they will have to bargain with devolved regional authorities rather than the provincial government. This is a problem if, as Lomas's research suggests, regional authorities do not view themselves as accountable to providers but rather to the citizens they serve.⁸⁹

Devolution of management control from ministries to RHAs may result in the centralization of hospital administrative control in RHAs. However, this is not a necessary feature of devolution. Many jurisdictions have experimented with "splitting," whereby RHAs assume the role of purchaser of health care services, and competing hospitals (in theory, at least) retain the role of providers.⁹⁰ If managerial powers are devolved to RHAs, it is not necessary for all providers of care to be consolidated into and managed by an RHA; in an IHS they would be a partner in a joint venture. There is no need to discard the long tradition of voluntary governance of locally owned hospitals and other institutions, and the entrepreneurial potential of independently governed organizations and practices. Indeed, as a political reality in Ontario, devolution is unlikely to occur unless hospital boards are retained and their opposition stance is thereby compromised. But to ensure the benefits of devolution, RHAs must receive funding for all hospital services, and hospital boards must negotiate performance agreements with RHAs. Hospitals therefore will become accountable to the RHAs rather than to ministries of health. To function effectively, RHAs must have the latitude to deal with hospitals and other providers in their regions in ways that will optimize the management of service

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88. For a sample of the arguments marshalled against devolution by the Ontario Hospitals Association, see Ontario Hospital Association, *Regional Health Authorities in Canada: Lessons for Ontario* (Toronto: Ontario Hospital Association, 2002). See also Canadian Medical Association, *Regionalization: CMA Policy Summary* (1996) 154:4 Can. Med. Assoc. J. 572A.

89. See Lomas, *supra* note 36 at 818.

90. See *supra* note 45.

delivery in accordance with the governance objectives articulated by the provincial government.

In Canada, physicians strongly oppose the transfer of funding for physician fees from provincial governments to RHAs.⁹¹ In the current centralized system, however, negotiations between ministries of health and physician associations over fees and services included within the Medicare basket are usually in gridlock. Moreover, it is widely agreed in policy circles that the current fee-for-service system of payment should be changed.⁹² Incentives should be created for physicians and other providers to encourage the right mix of quality and quantity of service. RHAs are better able than governments to tailor flexible payment structures to meet local needs, and to reach new accommodations and relationships with providers that will better serve the public interest.

It is true that there are serious technical and political challenges associated with devolution, and that it does not provide the ultimate solution to all of the problems inherent in publicly funded health care. Nonetheless, devolution is a critically important step in untangling governance from management responsibilities, and thereby strengthening lines of accountability. Its most powerful advantage is its ability to place the locus of responsibility for the management of health care at the point of delivery, where accountability to the people served can best be assured. A commitment to devolution is the first step in allowing governments to focus on steering rather than rowing in health care.⁹³ It permits provincial governments to concentrate their efforts on governing functional health care systems.

C. Devolution in Canada

This section analyzes the devolution experience in other Canadian provinces, and identifies actual successes, failures and barriers to

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91. Matt Borsellino, "Regional mumbo-jumbo displayed for what it is" *The Medical Post* (30 April 2002), online: The Medical Post <<http://www.medicalpost.com/mpcontent/article.jsp?content=/content/EXTRACT/RAWART/3817/08A.html>>.

92. For some criticisms of fee-for-service arrangements and alternative billing structures, see *supra* note 31 at 124 and *supra* note 32 at c.8.5.

93. Osborne & Gaebler, *supra* note 1.

effective reform. Quebec was the first province to devolve managerial responsibility to RHAs.⁹⁴ Since then, eight other provinces and one territory⁹⁵ have embraced devolution.

A review of evidence presented in primary and secondary literature indicates that devolution across Canada has resulted in a mixture of successes and failures.⁹⁶ There are two primary reasons for the failures. First, rhetorical rather than substantive devolution has been implemented. Second, no Canadian health authorities have received funding for key elements of the health care system (such as physician services and pharmaceutical services), so they have lacked a number of the levers essential to effective management. The greatest achievements of the devolution process are more recent and focus on the significant strengthening of accountability frameworks. We will now review these failures and successes.

(i) Rhetorical Rather than Substantive Devolution

In most provinces, devolution has occurred in form rather than substance.⁹⁷ Many health authorities remain subject to micro-management by the provincial Ministry of Health, so their work is more administrative than truly managerial.

Initially at least, RHAs were restricted to line-by-line budgets negotiated with and set by the Ministry of Health.⁹⁸ With limited

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

95. Ontario has not introduced devolution of authority; the Northwest Territories has eight health and social services authorities (HSSAs).

96. See e.g. Lewis & Kouri, *supra* note 39.

97. Although we put the point more strongly than other commentators, this is a problem identified by many. See e.g. *ibid.*; Lomas, *supra* note 36.

98. See e.g. the discussion in the British Columbia legislature where it was noted that “[w]hile for previous health authorities there was an attempt to give them flexibility and the ability to manage locally, they still had to meet targeted, line-by-line funding requirements. This year, starting yesterday, for the first time there will be a transfer, almost a lump-sum payment, and the health authorities will be responsible for that.” British Columbia, Legislative Assembly, *Official Report of Debates of the Legislative Assembly (Hansard)*, vol. 5, No. 4 (2 April 2002) at para. 1020 (J. MacPhail), online: <<http://www.legis.gov.bc.ca/hansard/37th3rd/h20402a.htm>>.

budgetary latitude, they had relatively little capacity to shift funds—for example, from hospitals to home care or from specialist care to primary care. This situation has recently improved. However, there are still some restrictions, and no studies have yet documented the regional variations in expenditures by category.

A survey of regionalization in Saskatchewan found that “respondents expressed concerns about the degree of boards’ autonomy from government in making decisions.”⁹⁹ There was a “lack of clarity in the division of authority between boards and Saskatchewan Health.”¹⁰⁰ Other problems identified in the survey include a perception that the board had legal responsibility for matters over which it had insufficient control, a perception that the government had laid down unduly restrictive rules and a feeling among board members that less authority was given than was expected when the districts were formed.¹⁰¹

The concerns illustrated in the Lewis survey are also seen in the results of a study¹⁰² conducted in 2001-2002 by the Canadian Centre for Analysis of Regionalization and Health (CCARH). In a survey of CEOs, board members and Ministry officials, CCARH found that one-third of CEO and Ministry respondents felt that there was a clear division of authority and that board members were evenly divided on the question.¹⁰³ A majority of board members and CEOs believed that RHAs had less authority than they should have, and approximately 70% felt that RHAs were too restricted by government rules.¹⁰⁴ Although there are limitations to surveys of opinions rather than facts, it is clear that, at least from the perspective of the devolved authorities

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99. Steven J. Lewis *et al.*, “Devolution to democratic health authorities in Saskatchewan: an interim report” (2001) 164:3 Can. Med. Assoc. J. 343 at 345. The survey was conducted in 1997 and reported in 2001.

100. *Ibid.* at 345.

101. *Ibid.*

102. Denise Kouri, Kelly Chessie & Steven Lewis, *Regionalization: Where Has All the Power Gone? A survey of Canadian decision makers in health care regionalization* (Saskatoon: Canadian Centre for Analysis of Regionalization and Health, 2002), online: CCARH <http://www.regionalization.org/Survey_02.pdf>.

103. *Ibid.* at 6.

104. *Ibid.* at 7.

themselves, there is confusion as to the respective roles of government and regional authorities.

(ii) Failure to Devolve Funding for Core Sectors

No province has devolved to RHAs fiscal responsibility for the full spectrum of health services. Most importantly, although compensation for health care providers is the predominant cost element in all components of the health care system, no RHA participates in determining levels of compensation or modes of payment for physicians, whether family doctors, specialists or hospital-based physicians.¹⁰⁵ As a consequence, RHAs have no funding or accountability relationship with the physicians who effectively determine the range and volume of services used, and have no access to the lever of wage rates for nurses and other health professionals. Also, the responsibility for managing funding for provincial drug plans has not been devolved to RHAs.¹⁰⁶

In summary, no Canadian RHA manages the “whole loaf.” Health services are an interconnected enterprise, and if RHAs are to deliver the advantages promised, they must have control over all elements of the system that can be integrated at a regional level. If they cannot co-ordinate all key elements of the system, they cannot manage effectively the elements for which they do have responsibility. As a result, the system tends to be oriented toward the delivery of services, rather than toward policy issues and health outcomes.

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105. Alberta is currently testing alternative payment plans, such as partnerships between physicians and RHAs for which the RHAs are funded by the province. However, no province has given sole responsibility to an RHA for physician remuneration within a region. Most RHAs have some sort of advisory role with respect to physician payments.

106. British Columbia has delegated authority for its Pharmacare plan to the Provincial Health Services Authority (PHSA), which is really an arm of the Ministry, as the PHSA is responsible for coordinating the other five RHAs and all province-wide health services, such as cancer care and organ transplants.

(iii) Accountability Frameworks

The experience with devolution across Canada indicates that its greatest accomplishment has been the improvement of accountability mechanisms.

In Alberta, all RHAs are required by law to develop a regional health plan,¹⁰⁷ which must include several components. First, it must state how the RHA will meet its statutory responsibilities and measures its performance in this regard.¹⁰⁸ Second, the plan must provide for establishing one or more community health councils (CHCs), and it must define their role as an advisory body to the RHA, as a body contracted by the RHA to provide services, or as both.¹⁰⁹ Third, the plan must incorporate information on the health services to be provided in the region and on any other information that the Minister requires.¹¹⁰ Fourth, at any time the Minister may require an RHA to produce a report on its activities. Finally, all RHAs must produce annual reports that are tabled in the legislature.¹¹¹

In Nova Scotia, the Minister of Health appoints a board of directors to administer, manage and direct the affairs of each district health authority (DHA).¹¹² A DHA must “provide information to the public about . . . the operations and activities of the authority,”¹¹³ and must submit an annual report that details “results achieved by the authority

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107. *Regional Health Authorities Act*, R.S.A. 2000, c. R-10, s. 9 [RHAA].

108. In accordance with s. 5(a) of the RHAA, *ibid.*, the RHA shall promote and protect the health of the region’s population, assess the health needs of the region, determine priorities for health services and resource allocation, ensure reasonable access to quality health care, promote responsiveness to the community and support the integration of services in the region.

109. *Ibid.*, s. 9(4)(c). The RHA may also delegate to the CHC any power or duty conferred or imposed on it by the RHAA, *ibid.*, s. 6(2).

110. *Ibid.*, s. 9 (4)(d), (e).

111. *Ibid.*, s.14(2). The annual report contains audited financial information, senior management and board remuneration, and any other performance information required by regulation (*i.e.* the Minister), *ibid.*, s. 14(2)(b).

112. *Health Authorities Act*, S.N.S. 2000, c. 6, s. 10 [HAA]. Interestingly, neither the DHA nor any person employed or engaged by the DHA is to be regarded as an agent for the Crown. *Ibid.*, s. 9.

113. *Ibid.*, s. 20(f).

with respect to any performance objectives established for the authority.”¹¹⁴ The Capital Health District Health Authority has an “Accountability” section on its website, with information on such matters as emergency room wait times.¹¹⁵

In British Columbia, the Ministry of Health Planning and the Ministry of Health Services are responsible for the overall planning and direction of the health care system. Both ministries hold the RHAs accountable for their performance. The legislation requires RHAs to develop regional health plans and to report to the Minister on their activities in pursuit of those plans.¹¹⁶

Of particular interest in British Columbia are the performance agreements established between the MHS and the RHAs. A report¹¹⁷ by the British Columbia Auditor General notes that several other provinces, including Manitoba¹¹⁸ and Saskatchewan, have used or are using similar agreements. New Zealand uses “Crown Funding Agreements,” the United Kingdom uses three-year performance plans, and New South Wales uses performance agreements. In 2002, the MHS signed agreements with each RHA that required the RHA to account for the delivery of patient care, health outcomes and the spending of

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114. *Ibid.*, s. 21(2)(b).

115. Online: Capital Health District Health Authority <<http://www.cdha.nshealth.ca/accountability/index.html>>. The section features a “Daily Review” intended to provide a snapshot of daily operations in facilities throughout the district. It also includes a quarterly report on “Operational Measures Indicators,” detailing responsiveness, system competency, community/client focus, and work life.

116. *Health Authorities Act*, R.S.B.C. 1996, c. 180, s. 5(1)(a), (v).

117. British Columbia, Office of the Auditor General, *2003/2004 Report 1: A Review of Performance Agreements Between the Ministry of Health Services and the Health Authorities* (British Columbia: Queen’s Printer, 2003) [Report of the B.C. Auditor General] at 11, online: Office of the Auditor General of British Columbia <<http://www.bcauditor.com/PUBS/2003-04/Report1/HealthMay2003.pdf>>. On 10 April 2003, “Manitoba’s Health Minister Dave Chomiak, Manitoba’s regional health authorities, CancerCare Manitoba and the Addictions Foundation of Manitoba . . . signed performance deliverable documents designed to provide greater accountability in Manitoba’s health system.” See Government of Manitoba, News Release, “Health Organizations Sign Accountability Documents” (10 April 2003), online: Government of Manitoba <<http://www.gov.mb.ca/chc/press/top/2003/04/2003-04-10-03.html>>.

118. Report of the B.C. Auditor General, *ibid.* at 70.

health dollars. These performance agreements are intended to be key documents outlining the connection and management of governance, accountability and performance within the health care system.¹¹⁹

In a recent report, the British Columbia Auditor General supported “the concept of increasing accountability through performance agreements.”¹²⁰ His office had previously “expressed concern about the lack of accountability in the health system.”¹²¹ From the perspective of governance, accountability and performance measurement and reporting, the Auditor General concluded that the agreements “need to evolve considerably before they can be regarded as effective tools.”¹²² With some recalibration, however, they “should become the key accountability documents between the ministry and health authorities.”¹²³

The British Columbia Auditor General’s Report included the following key recommendations.¹²⁴ First, the purposes of the agreements must be clearly defined.¹²⁵ They should outline who is to be held accountable for the performance expectations within the regional health care system. Second, the agreements should set clear objectives. Third, a more collaborative approach to drafting is required with a timeline that allows for greater participation by the RHAs. This drafting should be part of the ongoing management and decision-making process for both

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119. *Ibid.* at 1.

120. *Ibid.* See also British Columbia, *Information Use by the Ministry of Health in Resource Allocation Decisions for the Regional Health Care System* (Victoria: Office of the Auditor General of British Columbia, 2002), online: Office of the Auditor General of British Columbia <<http://www.bcauditor.com/PUBS/2001-02/Report6/HealthCare.pdf>>. This report concluded that the Ministry of Health was “allocating resources across the health care system without the benefit of essential cost and performance information.” *Ibid.* at 1.

121. Report of the B.C. Auditor General, *ibid.* at 1.

122. *Ibid.*

123. *Ibid.* at 2.

124. *Ibid.* at 5-6.

125. The agreements that the Auditor General looked at lacked a specific purpose. As a result, the Ministry and the RHAs held different views as to what the agreements were trying to achieve. See *ibid.* at 2. According to the Auditor General, clear descriptions were needed of responsibilities, objectives, performance measures, reporting requirements, incentives and consequences.

the Ministry and the RHAs. Fourth, performance measures should be confined to those that are critical for decision-making and are linked to objectives and improvement priorities. Fifth, reporting requirements should be based on information used in decision-making. The Auditor General also noted that other jurisdictions with similar agreements have independent review and audit processes to monitor these relationships. He urged the Ministry to consider instituting similar controls.

The Liberal government of Ontario has just passed the *Commitment to the Future of Medicare Act, 2004*,¹²⁶ known as Bill 8. The *Act* requires that hospital boards enter into accountability agreements with the Ministry of Health, as well as giving the Minister extensive powers to issue a broad range of compliance directives and orders. The *Act* does allow 90 days for agreement negotiation, but after this time has elapsed, the government may unilaterally impose an agreement on the hospital, without which the hospital's funding may be withheld.¹²⁷ While this is an important step forward in improving accountability within Ontario's system, it is tiny when compared to the leap that is needed. As we have discussed earlier, devolution provides the opportunity to integrate the silos of funding in the hands of one decision-maker so that the system can finally move toward the delivery of integrated health care. The effect of Bill 8 will be to leave those silos in place. Its focus only on hospital services, rather than on the full range of care, perpetuates the bias toward the delivery of care rather than health care outcomes.

IV: Situating Devolution Within A Comprehensive Reform

As we have said above, devolution is only a part of a series of interlocking initiatives that would, over time, improve the efficiency of a publicly funded health care system. We now turn to address the broader reforms necessary for the effective integration of devolution in a health care system.

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126. S.O. 2004, c. 5.

127. *Ibid.*, s. 23(3), (5).

A. Refocusing the Debate from Money to Governance

It is important to clarify that the crisis in health care in Canada and in many other jurisdictions is not solely or even primarily a funding issue, but is rooted in deficiencies in governance, management and accountability. The fact that wrangling about money¹²⁸ is almost the exclusive focus of health care policy discussion presents a serious impediment to reform. It creates a false impression that health care's problems can be resolved by spending more money. More importantly, it deflects attention from more fundamental issues: the state of national and provincial/territorial governance of the system; the need both to achieve inter-regional equity and to accommodate differences in regional needs; the need for measurable outcomes and effective health information management; and above all, the need for accountability to those served by the health care system.

To escape from this predicament, federal and provincial governments must acknowledge that many problems in health care stem from their lack of accountability for decisions. The two senior levels of government should publicly announce their collective determination to address current functional deficiencies in accountability for health care services and in the governance and management of those services from a country-wide perspective, as well as in each province and territory. Together, the federal and provincial governments should speak to the citizens of Canada, perhaps through the auspices of the newly minted Health Council of Canada. The Council should cut through the sterile bickering between provincial governments about levels of funding and providers' self-interested claims of under-funding and provide unbiased evidence about the quality, cost and availability of health care.

B. Clarifying Governance Roles

Clarifying the governance roles of both levels of government is the first step toward accountability in Canadian health care. A devolved

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128. According to Wildavsky's Law of Medical Money, costs will increase to equal the sum of all funds available—there is never enough money! See Aaron Wildavsky, "Doing Better and Feeling Worse: The Political Pathology of Health Policy" (1977) 106 *Daedalus* 105 at 109.

health care system requires effective coordination of its several parts, which in turn demands a clear vision and mission for the enterprise, along with the goals that must be satisfied to achieve both. As stated above, the sharing of responsibility between both senior levels of government for health care in Canada has led not to stronger governance, but to a virtual absence of both governance and effective accountability for the system's performance. To remedy this deficiency, detailed governance responsibilities must be assigned to each level of government.

On the federal level, the Romanow Commission's¹²⁹ extensive consultations showed that Canadians are deeply committed to the continuation and expansion of a publicly funded national health care insurance system that adheres to the principles of the *CHA*: universality, accessibility, comprehensiveness, portability and non-profit administration. Although these principles and the values they represent are important, the principles of the *CHA* themselves are too general to be useful in holding the federal government accountable for its role in governing health care. Comprehensiveness and other principles should be more explicitly defined, and converted into national policies that can then be measured and evaluated on a regular basis, preferably annually. This would provide greater system-specific accountability for the federal government's performance in meeting its governance responsibilities in health care.

The Health Council of Canada should be charged jointly by both levels of government with developing and recommending the adoption of national policies, designed to make governance responsibilities for health care explicit and measurable.¹³⁰ Furthermore, the federal government should develop plans, including specific goals and

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129. *Supra* note 29.

130. For some, this would not be a wise requirement, as it could involve the Council too closely with the existing system, rather than allowing it to be a fearless analyst, critic and exhorter. However, we fear the reality is that the Health Council will not be given the mandate, independence or powers to be truly outside the system, at arm's length from the government that established it. Consequently, we feel that the Council should be charged with the policy development that both levels of government have not been able or willing to do.

objectives, to provide predictable fiscal transfers to the provinces and territories.

With respect to the governance roles of provinces and territories, within the policy framework of a national health care system, substantial flexibility is essential to accommodate the wide differences in population, geography, cultures, traditions and other characteristics among and within Canada's provinces and territories. Provincial and territorial governments should articulate their particular regional visions and missions for health care, and should develop related short-term and long-term plans with measurable goals and objectives. Each government should also develop a policy framework encapsulating the values that it expects its health care system to exemplify and apply. The government should then be held to account for how effectively its health care system meets these governance objectives. The plans, particularly the government's policy goals and the progress of the RHAs toward meeting those goals, should be made transparent by tabling comparative performance data in the legislature every six months.

C. Incentives for Performance

In order to implement devolution in health care reform successfully, the government must move away from a primarily command and control (or rules/regulation) type of governance and toward an incentive-based system that promotes more effective performance by service providers and managers of the system. Incentives are far more important than penalties to ensure that managers, whether regional or central, achieve the goals and objectives set by government. Little attention has been devoted in any Canadian province to applying incentives to ensure that regional or district health boards are responsive and accountable to the citizens they serve.

This is not a failing peculiar to Canada. Most jurisdictions that have experimented with devolution have failed to offer effective incentives to ensure good performance. Rather, there appears to be an assumption that these regional bodies are inherently capable of cutting through the morass of vested interests in health care and serving the public interest. For example, U.K. Prime Minister Margaret Thatcher's internal market

reforms did not provide for penalties to be imposed on purchasers that arranged “bad” contracts for the supply of health care services, and this attracted significant criticism.¹³¹ These contracts denied patients care in the very same way as the alleged inefficiencies of the old command and control system. Similarly, the more recent New Labour Reforms in the U.K. do not impose any penalty or sanction for Primary Care Groups that perform inadequately, apart from the firing of managers.¹³² In New Zealand, no incentives were built into contracts for managers of RHAs (the purchasers) apart from the negative prospect of dismissal¹³³—a penalty that serves as a safety-valve, but is insufficiently nuanced to ensure good performance.

In the absence of incentives for RHAs and their managers, there is no engine to drive intelligent decision-making. In the public sector, there is the hope that the appointment of good and skilled decision-makers is sufficient to serve the larger public interest, but it is not. Decision-makers require not only skills, comprehensive information and necessary resources, but also incentives to make decisions that strike the right balance between the needs and values of patients and more broadly-defined societal interests.

There are many ways of designing incentive-based systems, and a myriad of possible incentives, to ensure good decision-making by those with devolved responsibility for governing and managing health care. For instance, RHAs and IHSs should not be punished, as hospitals now are,¹³⁴ for carrying a reasonable margin of surplus from year to year, but should be rewarded for investing savings in future innovation. Any prudent business retains earnings to smooth out economic cycles and invest in change. Developing and implementing incentives is the key to galvanizing and re-energizing the public health care system. It is important to note, however, that despite well-crafted incentives, the

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131. Pauline Allen, “Contracts in the National Health Service Internal Market” (1995) 58:3 Mod. L. Rev. 321 at 339.

132. U.K., Department of Health, *The New NHS: Modern, Dependable* (London: The Stationery Office, 1997) at s. 5.26, online: Official-documents.co.uk <<http://www.archive.official-documents.co.uk/document/doh/newnhs/wpaper5.htm>>.

133. See Flood, *supra* note 12, c. 4.

134. Janice Gross Stein, *The Cult of Efficiency* (Toronto: House of Anansi Press, 2001) at 111.

ability of any central government to monitor a regional body's performance may be limited by political factors (that is, by the government's search for short-term political gain through inappropriately sanctioning an RHA, or through failing to reprimand it for poor performance). It is, therefore, important to consider the incentives for RHAs to become directly accountable to the people they serve.

Conclusion

Devolution inserts a new decision-maker between regional providers and patients and the principal funder—the government. The logic of devolution¹³⁵ is based on the assumption that changing the position or level where power resides improves accountability for the health care system and improves the system's performance.

Ontario continues to centralize its management and operational functions in the Ministry of Health and Long-Term Care, both in Toronto and its regional offices. This policy defies strong arguments in favour of delegating or devolving managerial responsibilities to regional, community-based organizations better able to discharge the detailed and sophisticated responsibility of managing the provision of health care services.

The benefits of devolution are not immediately apparent or measurable over the short term; the effects are long-term and systemic. In addition, devolution itself is only a part (albeit an important part) of a comprehensive solution for the reinvigoration of publicly funded health care in Canada, and no province has embraced a comprehensive set of reforms that harness incentives to achieve public sector goals. Furthermore, devolution has been implemented in most Canadian provinces in a manner that ensures it will not succeed, at least not fully. Despite the rhetoric, devolution of managerial responsibility has not in fact occurred; provincial ministries still closely centralize managerial decisions. Most importantly, fiscal responsibility for key elements such

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135. Ontario, Premier's Council on Health, Well-Being and Social Justice, *A Framework for Evaluating Devolution* (Toronto: Queen's Printer, 1994).

as physician services and the determination of rates of pay for all providers and employees, has not been transferred. These interconnected factors serve to hinder successful devolution in Canada.

After several decades of Medicare, the general public in Ontario considers the provincial government to be directly responsible for every problem in health care, imagined or real. Public opinion in this regard is highly conditioned by two major forces: the providers of health care services and the media. The government is in the unenviable position of being held accountable for a health care system that does not really exist. Among the providers of health care services—hospitals, physicians, pharmacies, nursing homes, home care providers, dentists, and so on—very few, if any, would freely acknowledge that they contribute collectively to the functioning (or non-functioning) of a system, much less that they are accountable to the Minister of Health and Long-Term Care for their performance. The Minister and government assume the role of governance only with respect to providing the majority of funding from tax revenues, and to taking the blame when things go wrong. It is an example of responsibility without authority. It is not effective or sustainable.

Devolution of power and authority over health care services to RHAs, IHSs or other subsidiary bodies will not solve all the ills of health care. Nevertheless, it will encourage effective governance in health care systems, and it promises to bridge the yawning gaps in management and accountability.

Postscript

On October 6th, 2004, as this article was in the final stages of editing, the Ontario government announced the establishment of 14 Local Health Integration Networks that will “plan, co-ordinate and fund health care services locally along geographic boundaries.”¹³⁶ What will distinguish these Networks from RHAs in other provinces is that they will not manage hospitals (that is, they will not subsume within their

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136. See online: Government of Ontario <http://ogov.newswire.ca/ontario/GPOE/2004/10/06/c7765.html?lmatch=&lang=_e.html>.

organizational structures the direct management of the existing hospital boards). Board members will be appointed by the government and bound by performance agreements with the Minister.¹³⁷ Details about the new Networks are sketchy; the government appears still to be in the planning stage of this initiative, and to be consulting with various stakeholders. The challenge for the government will be to recognize that although it characterizes the initiative as “made in Ontario,” there are in fact decades of experience with regionalization and devolution, both across Canada and in other jurisdictions, that should not be ignored. Rather than reinventing the wheel and making the same mistakes that other provinces have made, the Ontario government should seize this opportunity to get it right from the beginning.

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137. See online: Ontario Ministry of Health and Long-term Care <http://www.health.gov.on.ca/transformation/lhin/100604/lhin_bul_1_100604.html>.