Whither Canadian Hospitals: Aligning Authorities and Accountabilities

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SUMMARY: The Canadian healthcare system, not unlike many around the world, is undergoing tremendous change. Nowhere have these changes been more dramatic than in what used to be known in Canada as the "hospital sector". The world-wide symbol of the blue "H" can still be seen in over 1000 communities and different highways across Canada. However, over the past decade, as legal entities, hospitals have been deemed to no longer exist in all provinces save one, our largest province: Ontario. Elsewhere, an increasingly broad range of hospital and community-based services are administered through Regional Health Authorities or RHAs. This short piece attempts to provide a high-level description of the nature of these changes as well as the economic, technological and political forces behind them, and briefly assess the implications for the national voice of "hospitals".

Taking Stock: Canada has a universal, publicly financed health insurance system with virtually all medical services and about 90 percent of all hospital services paid for by the public purse. Since the 1950s and 1960s, all Canadians are covered and according to some of the most meaningful metrics, Canada's healthcare system continues to serve Canadians reasonably well in terms of access to essential or acute care services[1]. Canada also seems to be "bending the cost curve" in terms of public sector healthcare spending (see below) and compares well when it comes to administrative efficiency and "care processes"[2].

That said, according to the Organization for Economic Cooperation and Development[3] and the Commonwealth Fund[4], Canada continues to lag behind many of our comparator countries in terms of overall value for money. For example, we continue to rank in the top tercile in terms of per capita spending, while occupying the bottom tercile in terms of key performance indicators such as wait times and access to primary care. While we do well in terms of overall life expectancy, we continue to fall further behind in terms of infant and maternal mortality. There is also growing public and political concern in Canada over health status disparities among and between Canada's indigenous peoples[5].

Responsibility for the financing and delivery of healthcare in Canada rests primarily with the ten provinces and three territories. The federal government provides substantial annual cash transfers to the provinces and territories in return for compliance with criteria and conditions set out under the Canada Health Act (1984)[6]. In brief, the conditions are: *Reasonable access* (without point-of-services charges) to a *comprehensive* range of insured hospital and medical services, on a *publicly administered* basis, with *portability of benefits* when moving or travelling within Canada, with *universal population coverage*.

Over the last few years and over the past five years in particular, hospital sector governance has changed markedly. By 2017, every province in the country except Ontario has put in place Regional Health Authorities (RHAs) that span a much broader range of services than traditional in-patient and outpatient hospital services. RHAs have been formed with delegated authorities and embrace accountabilities for a wide range of services (i.e. more of a "population health" mandate), reporting to arms-length, largely appointed Boards of Directors, as opposed to elected Boards. Most physician services are still settled on a fee-for-service basis (approximately 70%) and tend to operate outside the locus of accountability of the RHAs.

1 See most recent Canada Health Act Annual Report to Parliament: https://www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2015-2016.html
2 Commonwealth Fund "Mirror, Mirror" 2017 http://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-international-comparisons-2017
3 OECD, June 2017. See link accessed Oct 5, 2017: http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_STAT
4 Commonwealth Fund (2017), Op. Cit. Across Canada, Ontario and British Columbia rank in top tercile, while provinces in eastern Canada rank at or near the bottom.
5 HealthCare*CAN* link: http://www.healthcarecan.ca/resources/issue-briefs/
6 See Canada Health Act Annual Report to Parliament: https://www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2015-2016.html

Table 1: De-regionalization and Centralization of Canada's Healthcare System

Province/Territory	Regional entities	Brief Description
British Columbia	7	Regionalized (2001): Five geographic Regional Health Authorities (RHAs); One Provincial Health Service Authority responsible for speciality services (e.g. cancer care); and First Nations Health Authority (2013).
Alberta (AHS)	1	Re-regionalized (2008): Single, province-wide Alberta Health Services with 5 operational zones (2011); AHS created out of 9 geographic regional entities.
Saskatchewan	1	De-regionalized (2017): Single, province-wide authority created by consolidating 11 geographic RHAs; retained province-wide specialized and shared services responsibility.
Manitoba	5	Regionalized (2012): With recent consolidation of clinical services within Winnipeg RHA and strengthening of province-wide responsibility for speciality services and shared services[7].
Ontario	14	Decentralized (2004): Elected Hospital Boards continue to exist, but increased responsibilities and authorities have recently been vested with 15 Local Health Integration Networks (LHINs) by subsuming Community Care Access Centres (CCACs).
Quebec	18	Regionalized (2015): Two-tiered regionalized structure, with 18 Regions working through/with 34 integrated health and social service institutions[8].
New Brunswick	2	De-regionalize (2008): Eight geographic RHAs were amalgamated into two: Vitalité to coordinate services the francophone population and Horizon to service the needs of the rest of the province. Province-wide clinical and information services are provided through a province wide agency known as "Facilicorp NB".
Nova Scotia	1	De-regionalized (2015): The Nova Scotia Health Authority (NSHA) was the result of the merger of nine RHAs. Like Alberta, there are operational "zones" or areas supported by province-wide shared services.
Prince Edward Island	1	De-regionalized (2010): Health PEI is the single authority with responsibility for province-wide coordination of services. This crown corporation was created by merging five RHAs
Newfoundland and Labrador	4	Regionalized (2003): The province continues to rely on one large RHA operating out of St. John's to coordinate specialty series province-wide, with three geographic specific RHAs to provide local services.
Yukon Territory	-	Centralized: Yukon does not have a regional health authority. It has three hospitals run by the Yukon Hospital Corporation.
Northwest Territories	1	De-regionalized (2015): One Health Authority has been established, a Territorial Board of Management replacing eight authorities.
Nunavut Territory	-	Centralized, with responsibility resting with the Department of Health and Social Services.

7 Manitoba is undergoing further "sweeping reforms" in terms of centralizing specialty care services province-wide. See this link for most recent description: http://www.cbc.ca/news/canada/manitoba/winnipeg-health-care-closures-1.4308163

8 See following link describing health regions across Québec: http://www.msss.gouv.qc.ca/en/reseau/regions.php

Furthermore, many geographic-specific health authorities have been recently consolidated to provide for a better alignment of authorities and accountabilities at provincial level, to achieve better coordinated and integrated hospital and community-based care. Not unlike several other countries in Europe (e.g. Norway, Denmark, Sweden, Finland) and the UK, Canada has struggled to realize the full potential of regionalized systems and has recently re-centralized or de-regionalized provincial/territorial systems. Delivering high quality care in a cost effective manner in rural and remote areas remains very problematic in Canada[9].

The current governance arrangements for each province and territory are summarized above (see Table One)[10].

As Barker and Church (2016)[11] point out, this process of regionalization followed by de-regionalization and consolidation has been driven by several factors. These include:

1. Citizen engagement or community participation: In the early years, regionalization was explained or couched in terms of "putting patients first" or "closer to home". For both economies of scale and political accountability reasons, recently there has been increased attention to the improved alignment of authorities and accountabilities, on a province-wide basis.
2. Service delivery and integration: The over-riding policy objective in 2017 is improving overall continuity of care under the banner of a "population health" approach. Province-wide Health Authorities (HAs) across Canada have responsibilities, from traditional "downstream" programs (in-patient/acute and outpatient care services), long term care and home/community services through to "upstream" programs, such as public health and health promotion.
3. Community-based Care and Cost containment: While mitigating cost increases has tended to be downplayed, we have in fact seen a "bending of the cost curve" when it comes to overall public-sector healthcare spending in Canada[12]. Since 2010, the rate of growth in per capita health spending has barely kept apace with the rates of inflation and population growth combined. While hospitals still account for the largest share of overall spending (29.5%), this slice of the pie has decreased by about 25% since the 1990s, remaining stable since the early 2000s. It is experiencing its lowest rate

9 Importantly, in most jurisdictions, private, not-for-profit hospitals under the auspices of religious organizations are not part of these new province-wide authorities.

10 This table draws heavily on two recent, reports on trends to concentrate or de-regionalize governance of Canada's healthcare systems. See: Barker and Church (2016). Revisiting Health Regionalization in Canada: More Bark than Bite? International Journal of Health Services; and Bergevin et. al. (2016): Toward the Triple Aim of Better Health, Better Care and Better Value for Canadians: transforming regions into high performing health systems, Canadian Foundation for Healthcare Improvement.

11 Barker, P. and J. Church (2016) Op. Cit.

12 See the recent report from the Canadian Institute of Health Information: https://www.cihi.ca/sites/default/files/document/nhex-trends-narrative-report_2016_en.pdf

of growth since the late 1990s, reflecting the restraints of provincial and Territorial budgets.

Other factors driving the need for reform include technology and demography. For example, the advent of *Dr. Google* has created a new, more informed and demanding pool of patients. Conjoint decision-making is increasingly the norm. While the costs of many technologies are increasing, they have also helped hospitals cope with increased demands, through fixed resources (e.g. drug reconciliations, digital radiology and better discharge planning).

In terms of demography, while Canada still has a relatively young population, it is aging rapidly. For the first time, Canadian seniors (65+) now outnumber those under the age of 15. As the baby boomers grow older, hospitals need to improve the integration of home and institutional care, informal and formal care, offering patients better assistance in navigating the system. More resources and attention are now being directed to chronic, long term care while streamlining acute care hospital services[13].

Demographics is also taking a toll on the health workforce, with estimates as high as 50% of hospital workers retiring by 2030. As Dickson and Tholl (2016)[14] found, one of the biggest challenges is a growing leadership gap, partly due to the aging workforce:

> *"The challenge of creating large-scale change requires levels of systems thinking, strategic thinking, relationship development and self-leadership that supersede the current capacity of many formal leaders".*

This echoes earlier findings by the Health Council of Canada, that leadership is the most important enabling factor in successful health reforms, and by the Council of the Federation, which found that "present leadership" was essential in terms of effectively scaling and spreading healthcare innovations across Canada[15].

Looking ahead. Given the significant changes in regionalization and a renewed focus on the economics of healthcare services, the world-wide symbol of the blue "H" and its role across the continuum of care is being redefined across Canada.

There are at least three recent policy initiatives at the national level that have yet to play out in Canada's healthcare system. The *first* is the recent agreement between the federal government and the provinces/territories, under the banner of a new health accord[16]. The new 10-year agreement provides for an additional $11 billion and signals a more activist federal health agenda[17]. This is over and above annual increases under the Canada Health Transfer ($38 Billion/year), which will continue to grow at a minimum of three percent per annum, or the three-year moving average of GDP (whichever is greater). These additional amounts are targeted on two shared high priorities for the Canadian healthcare system: mental health ($5 billion over 10 years) and home care ($6 billion over 10 years). These are two areas where Canada has traditionally lagged behind other industrialized countries. Current federal/provincial/ territorial discussions revolve around reaching agreement on the metrics of success in investing in these two strategic areas.

The *second* federal initiative is aimed at reducing the health gap between and among Canada's Indigenous peoples. The federal government remains constitutionally responsible for providing for the health and social service needs of Canada's First Nations, Inuit and Metis. This is a segment of our population that is recording the fastest rate of population growth. Sadly, the life expectancy of this segment of our population is approximately ten years shorter than the average Canadian, while infant and maternal mortality rates are 3-5 times higher than the Canadian average. In the last federal budget, an unprecedented commitment of $825 million over five years was allocated to start working differently with Indigenous leaders. Another unprecedented move consists of the federal government's split of the former department of Indigenous and Northern Affairs into two departments, with the former Minister of Health now serving as the new Minister of Indigenous Services[18].The intent here is to work with the indigenous leaders to improve federal health and social support services integration, under arrangements that provide for increased autonomy and clearer lines of "by first nations, for first nations" authority and accountability[19].

Finally, the new federal Minister of Health, The Honourable Ginette Petitpas Taylor, announced in October 2017 an *External Review of Federally Funded Pan-Canadian Health Organizations*[20]. This review has been expected for some time and covers all eight such organizations that have evolved over the past twenty years[21]. Its premise is that improving the responsiveness and sustainability of Canada's healthcare system requires *strong national leadership* and greater pan-Canadian collaboration. The overall mandate of the review is to "ensure the role and structure of the Pan-Canadian Health Organizations is optimized to maximize the reach and impact of federal investments in these (eight) organizations."

Conclusions. Canada's health system is undergoing unprecedented changes in terms of governance structures and administrative processes. What do these changes mean for Canadian "hospitals", health authorities and other institutional care providers? The de-regionalization of provincial/territorial health systems is still ongoing, but it has already resulted in significant governance changes, locally and nationally. There is an increased preoccupation over the improved alignment of authorities and accountabilities in the system. Most provinces have concentrated authorities and accountabilities under health authorities, under the auspices of appointed Boards. Operational responsibilities are increasingly being vested with "zones". Hospital services are increasingly being provided on an outpatient basis, with a focus on decreasing lengths of stay. There is also a country-wide focus on reducing the number of Alternate Level of Care (ALC) Patients, with increased investments in integrated homecare programs.

Nationally, these changes are what helped trigger the merger of two longstanding national organizations as the voice of hospitals to merge to create HealthCare*CAN* in 2014[22]. Our traditional advocacy

13 Government of Canada (2017) News Release: Government of Canada implements new legislative changes to the Citizenship Act

14 Dickson, G and Bill Tholl (2014) Cross Case Analysis Final Report: Canadian Health Leadership Network: http://chlnet.ca/wp-content/uploads/PHSI-Cross-Case-Analysis-Report-2014.pdf

15 Council of the Federation (2012) From Innovation to Action: First Report of the Health Care Innovation Working Group. 28 p.

16 See: New 2017 Health Agreement https://www.canada.ca/en/health-canada/news/2017/08/canada_and_manitobareachagreementontargetedhealthfunding.html

17 This follows a period going back to 2006 where the previous federal government took a more laissez fare approach to health policy, deferring to provincial program administration with little or no accountability for federal funding increases that were locked in at 6% growth per year.

18 See August 2017 announcement: http://pm.gc.ca/eng/news/2017/08/28/statement-prime-minister-canada-changes-ministry

19 The former Minister of INAC (The Honourable Carolyn Bennet) will now form a new ministry responsible for Crown-Indigenous Relations and Northern Affairs

20 Health Canada: See Link: https://www.canada.ca/en/health-canada/programs/external-advisory-body-pan-canadian-health-organizations.html

21 They are: Canadian Institute of Health Information; Canadian Patient Safety Institute; Mental Health Commission of Canada; Canadian Foundation for Healthcare Improvement; Canadian Partnership Against Cancer; Canadian Centre on Substance Use and Addiction; Canadian Agency for Drugs and Technologies in Health; and Canada Health Infoway.

22 HealthCare*CAN* is the result of a merger between the former Canadian Healthcare Association (CHA) and the Association of Canadian Academic HealthCare Organizations (ACAHO). For a detailed description of the merger and the mandate of HealthCare*CAN* see: see HCC website at www.healthcarecan.ca.

and representation roles have evolved. More attention has come to focus on what the federal government can or should do directly at a pan-Canadian level, to help provinces and territories respond to demographic, economic and technological pressures on the health system. More advocacy is also now focused on the federal government's direct responsibilities in areas such as health information, infrastructure, public health and safety, health research and indigenous health. More attention is now focussed on helping HealthCare*CAN* members lead change and provide required professional training and development opportunities for staff through *CHA Learning*.

In an ongoing effort to demonstrate value and make a concrete difference, HealthCare*CAN* has developed a new, more representative governance structure and a new strategic plan that repositions itself as the *one voice* of the institutional community across Canada, speaking out on shared issues and concerns. Given our limited resources, this has also meant reaching out to other national organizations to form issue-specific and (often) time-limited coalitions to address issues such as antimicrobial resistance, the opioid crisis and cybersecurity: issues that know no provincial/territorial boundaries.

Many of our priority issues, such as cybersecurity and antimicrobial resistance, transcend international boundaries, underscoring the importance of continuing to work with the International Hospital Federation and our sister organizations such as the American Hospital Association. We welcome this ongoing dialogue and the sharing of information and strategies to deal with the evolving role of hospitals around the globe.

Biographies

Bill Tholl currently serves as senior consultant in health policy and leadership development. Until July 2017 he served as the Founding President and CEO of HealthCare*CAN*: the voice of Canada's health care organizations and hospitals. Prior to his appointment in March 2014, Bill served as Founding Executive Director of the Canadian Health Leadership Network (2009-2014); CEO and Secretary General, Canadian Medical Association (2001-2008), and CEO of the Heart and Stroke Foundation of Canada (1995-2001).

The Globe and Mail has described Bill as "Medicare's Mr. Fix-it". He is a sought-after speaker, being billed recently by CHLNet as a "leader of leaders" on the Canadian health scene.

He holds a graduate degree in health economics (from University of Manitoba) and has written on many topics, most recently as the lead author of "Twenty Tips for Surviving and Prospering in the Association World" (CSAE 2010) and is co-author of "Bringing Leadership to Life in Health" (Springer, January 2014). He is the recipient of numerous national awards and is a Certified Corporate Director (ICD.D).

Born and raised in Saskatchewan, Bill and his wife, Paula, live in Ottawa and have three children and three grandchildren.

Paul-Émile Cloutier was appointed President and CEO of HealthCare*CAN*, on June 12, 2017.

Before coming to HealthCare*CAN*, Paul-Émile Cloutier was Vice-President of Advocacy and External Relations of Genome Canada, where he was responsible for managing government and stakeholder relations, communications, events and sponsorships.

Prior to that, he spent 11 years at the Canadian Medical Association, initially as Assistant Secretary General, and then as CEO and Secretary General responsible for strategic planning, stakeholder relations and alliances, as well as overseeing the policy direction of the Association.

Mr. Cloutier also worked as a senior executive at VIA Rail Canada and for the Ontario Minister of Intergovernmental Affairs. He has held a number of policy and strategic direction positions in the federal departments of Immigration Canada, External Relations and International Development, and Indigenous and Northern Affairs, where he honed an excellent understanding of the federal-provincial dynamic.

A Montreal native, Mr. Cloutier is fully bilingual and holds two master's degrees (Health Administration and Political Science) and two bachelor degrees (Social Sciences and Political Science) from the University of Ottawa, where he has also been a lecturer in Political Science.

Over the years, Paul-Émile has been an active member in the community and served on a number of Boards, including his current role on the Kemptville District Hospital Board.

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