Devolving authority for health care in Canada's provinces: 4. Emerging issues and prospects

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Abstract

DEVOLUTION OF AUTHORITY FOR HEALTH CARE is evaluated in the context of 3 objectives of provincial governments — community empowerment to garner new allies for health care restructuring, service integration to create a true "system" and conflict containment as spending is cut. Devolved authorities cannot pursue each of these objectives with equal vigour because they must balance the competing pressures from their provincial government, their providers and their local citizens. Each devolved authority accommodates these pressures in its own way, through different trade-offs. Appointed board members are generally well intentioned in representing the interests of their entire community but are unlikely to overcome formidable barriers to community empowerment in health care. Unless future board elections attract large and representative voter turnouts, they may fragment board members' accountability (by making them more accountable to multiple interest groups) rather than solidify it (by making them more accountable to the community). Although boards have integrated and rationalized parts of the institutional sector, integration of the community sector is hampered by structural constraints such as the lack of budgetary authority for a broader scope of services, including physicians' fees and drugs. Devolved authorities will deflect blame from provincial governments and contain conflict only while they believe that there is still slack in the system and that efficiency can be improved. When boards no longer perceive this, they are likely to add their voices to local discontent with fiscal retrenchment. Continuing evaluation and periodic meetings of authorities to share experiences and encourage cross-jurisdictional policy learning are needed.

Résumé

LA DÉLÉGATION DE POUVOIRS DANS LE DOMAINE DES SOINS DE SANTÉ a été évaluée dans le contexte de 3 objectifs des gouvernments provinciaux — habiliter les communautés à mobiliser de nouveaux alliés pour la restructuration des soins de santé, intégrer les services pour créer un véritable «système» et limiter les conflits au moment où l'on réduit les dépenses. Les administrations qui ont reçu de nouveaux pouvoirs ne peuvent chercher à atteindre chacun de ces objectifs avec autant de vigueur parce qu'elles doivent établir un équilibre entre les pressions divergentes imposées par le gouvernement de leur province, leurs fournisseurs et la population locale. Chaque administration fait face à ces pressions à sa propre façon, par des compromis différents. Les membres nommés aux conseils d'administration sont en général bien intentionnés et veulent défendre les intérêts de toute leur communauté, mais ils ont peu de chance de surmonter les obstacles intimidants à l'habilitation communautaire dans le domaine des soins de santé. À moins que les prochaines élections aux conseils d'administration n'attirent des électeurs nombreux et représentatifs, elles risquent de fragmenter l'imputabilité des membres des conseils (en les obligeant à rendre davantage compte à des groupes d'intérêt multiples) au lieu de la solidifier (en les obligeant à rendre davantage compte à la communauté). Même si les conseils ont intégré et rationalisé des parties du secteur institutionnel, des contraintes structurelles comme le manque de pouvoirs budgétaires sur un éventail élargi de services, y compris les honoraires des médecins et les médicaments, ont nui à l'intégration du secteur communautaire. Les administra-

tions nouvelles ne protégeront pas les gouvernements provinciaux contre le blâme et ne confineront les différends que si elles croient qu'il reste du jeu dans le système et qu'il est possible d'améliorer l'efficience. Lorsque les conseils croiront que ce n'est plus le cas, ils risquent d'ajouter leur voix au mécontentement local face au repli budgétaire. Une évaluation continue et des réunions périodiques au cours desquelles les administrations partageront leurs expériences et encourageront l'apprentissage stratégique entre les niveaux de compétence s'imposent.

It has been said that there are no new policy debates in health care, just a constant revisiting of the same debate about who should govern and manage the system.[1] The relocation of at least some authority for health care from provincial governments to regional or local boards can be viewed as another episode in this debate. It is an episode in which both the governors and the governance tools may change. It is also an episode driven significantly by the politics of fiscal retrenchment.[2] In this fourth and final paper in the series on devolving authority for health care in Canada's provinces, emerging issues and future prospects are outlined in the context of these managerial and fiscal changes. Results from our survey of the board members in 5 provinces are used to evaluate the status of devolved authorities when appropriate.

Devolution objectives: new governors, new governance tools and fiscal retrenchment

Geographic relocation of authority has been accompanied, in at least some of the provinces, by efforts to increase citizen representation and participation in the health care system.[3–8] To the extent that these initiatives are ingenuous and successful, local citizens or their representatives will become the "governors." However, such citizen control, always tenuous in health care,[9,10] will only come about if provincial governments discard their ambivalence toward representatives of the local community and if health care providers agree to be governed by these representatives.

Provincial governments, however, do not necessarily see citizen control as an end in itself. Instead, citizen governors are seen as a means to a variety of ends. They may be agents of rationalization, integration and coordination, or allies in expenditure reduction, allocation of scarce resources and "taming" of powerful interest groups. The ambivalence of provincial governments comes from their fear that citizens' voices will rise not in support of but in opposition to government objectives. Governments fear that citizens will refuse the roles of agent and ally and derail provincial governments' ideas of a more effective and efficient health care system.

Most providers, from professionals and unionized workers to agencies and institutions, have become employees of the newly created structures or depend on these structures. This is the centralizing element of decentralization. These providers are expected to relinquish much of their previous autonomy and adhere to decisions made in the interests of "the system"; preservation of private domains is expected to give way to accommodation of public objectives. Not surprisingly, the most vocal opposition to the role of the devolved authorities has come from providers, who feel disenfranchised from decision-making previously under their control.[11–13] The "evolution of devolution"[14] is, as described in the first article of this series (*Can Med Assoc J* 1997;156:371-7), concerned with the balance of power among local citizens, provincial governments and health care providers.

There is also the debate about the approach to governance and management. For some provincial governments, community empowerment is less important than rationalization of and expenditure reduction in the health care system.[15,16] According to Tuohy's[17] method of categorizing management tools, these provincial governments have favoured "hierarchy" over "collegiality" or "the market."

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.[18] This pact made it difficult for provincial governments to replace collegial management with either hierarchy or the market. The inadequacy of blunt budgetary tools, the passage of time, the development of information tools and the demonstration of inappropriate care have all conspired to justify blending hierarchy with collegiality for more aggressive governance of the system. Geographic relocation of some authority has become a way for provincial governments to shed the shackles of their Medicare-pact history and, under the cloak of devolved authority, adopt a "command-and-control" strategy, especially with regard to hospital restructuring.[19]

One cannot ignore the political context of these structural changes. Provincial governments in Canada have been quick to emulate their federal counterpart and governments in many other countries that are engaged in fiscal retrenchment. Devolution of authority has been used as an avoidance strategy by governments faced with tough choices as service expectations exceed perceived taxation capacity.[2,6,20]

Three overarching objectives of devolved authority swirl around provincial health care policy-making, in a variety of mixtures and changing alignments.[8] First is the need to acquire allies, in the form of local citizens, for health care restructuring.[21] By using community empowerment, governments hope to establish an alternative source of legitimate power over dominant interests that have historically prevailed. For example, 72% of the board members in our survey felt accountable to all of the local citizens, but only 2% felt accountable to local health care providers.

Second is the desire to exact more than blunt budgetary control over health care providers. Local needs assessments, regional budgets, practice guidelines and business plans — in short, information for high-quality clinical care and sound business management — are all seen as ways of creating an integrated, effective and efficient system. Most of the board members we surveyed declared that improved effectiveness and efficiency of the system was their highest priority.

Third is the desire to reduce overall spending with a minimum of community complaint and to deflect complaints away from the provincial government. Of the surveyed board members, 57% believed that this was their provincial governments' main motivation for devolving authority. The budgets of most devolved authorities have been constrained or reduced in their first years of operation. Their capacity to absorb further spending cuts without community complaint depends not only on the size of the cuts but also on the boards' degree of perceived legitimacy, their progress in creating and rationalizing the delivery system and their willingness to challenge the provincial government.

To evaluate whether devolution "works," its current status and likely prospects must be evaluated against each of these objectives.

Creating new governors: community empowerment, representation and accountability

One of the many paradoxes of devolved authority is that the objective of community empowerment could be met fully while the health care system is left unintegrated, uncoordinated and unrationalized. Community empowerment means only that local citizens feel that they are in control of the decisions that affect the delivery of their health care. There is only a presumed and largely unproven link between citizen control and a more cost-effective health care system that delivers the same or higher levels of service with fewer resources. Regional or local control, we are told, is somehow less susceptible to the overtly political pressure of powerful interests and is more likely to engage in rational, evidence-based decision-making. However, why this balance is more attainable at a regional than a provincial level is never fully elucidated or completely obvious.[22]

There may be valid reasons why community empowerment is a justifiable goal, independent of whether it achieves rationalization of the health care system. Although our survey results showed that 50% of the members of the boards of the devolved authorities felt constrained by their provincial governments, the appointed board members overwhelmingly felt confident about their decision-making and influential in their role. However, there is no reason to believe that these feelings of empowerment among the appointed board members reflect the feelings of the community members they govern.

For community members to feel empowered they must feel that they are represented by the decision-makers on the boards, they must ascribe legitimacy to these decision-makers and they must at least tolerate if not support the decisions made. Our data on the backgrounds of the board members clearly indicated that current appointees are not sociodemographically representative of the community, which leaves open the question of how well they may represent the views of the community. One-third of members viewed themselves as representing a geographic or group interest; the other two-thirds saw themselves as representing and being accountable to all of the local citizens. One cannot determine in a general way whether the boards members' stated intentions and desires translate into local citizens' feeling that they are being represented, or whether local citizens perceive the boards as legitimate and at least acquiesce to their decisions. These can only be ascertained through assessments specific to each jurisdiction. Those assessments that have been done show that pessimism appears to predominate,[4,5,8] even when board members are elected and therefore have greater political legitimacy.[6,7]

The function of elections is not only to increase empowerment via legitimacy, it is also to increase accountability to the electorate — in theory, the entire community; in practice, those to whom board members feel beholden. The 40% of the respondents to our survey who were willing to stand for election expressed a greater tendency than the others to represent specific interests. If elections were ward-based, they would create a natural incentive for members to represent geographic interests. If hospital workers elected a hospital representative, rural areas a rural representative, social service agencies a social service representative, and so on, then a single accountability to the community would be disaggregated into multiple accountabilities to a variety of group and geographic interests. This is precisely the "management by interest group" approach that devolved authority was designed to overcome.

As Rasmussen[6] states, "The province provides health care services, but individuals are unlikely to organize to influence the policy process related to health care if they cannot, in some measurable way, privately appropriate the public good. . . . Those with material interest in the issues will organize most quickly and most effectively, almost always in defence of the status quo." Our work shows that those employed in health care have a greater propensity than other citizens to become involved in local health care decision-making[23] and that the "average" citizens are ready to assign local decision-making to "health care experts."[24] Compared with appointment, elections may, paradoxically, reduce rather than increase the accountability of local boards to the community and leave community empowerment untouched or even reduced.

A final reason to be sceptical about the ability of devolved authority to empower local communities is the centralization that accompanied their creation. In most provinces, the local, autonomous boards governing institutions, agencies and services were disbanded and their mandates and powers incorporated into their area's new devolved authority. In Saskatchewan, for instance, 435 such boards were replaced by 30 district boards. The logic of this measure in the context of rationalization, integration and coordination of the health care system is fairly obvious. Its effect on opportunities for individual citizens to feel that they are contributing and participating is less well recognized. Assuming that each disbanded board had 12 members, the same number of members as the replacement boards, 5220 opportunities for local participation have been replaced with just 360 opportunities. This has presumably "disempowered" nearly 5000 citizens. One of the future challenges for devolved authorities is to find ways to harness the energy of these discarded volunteers and recreate the "social capital" they represent. As Putnam[25] has demonstrated, such social capital is vital to effective governance by regional authorities.[26] Furthermore, replacing 435 community boards with 30 district boards may, by virtue of sheer volume of work, give greater control to staff and less influence to the remaining board members.

Creating a health care system: rationalization, coordination and integration

Regardless of its ability to empower communities, devolved authority may be able to rationalize the local or regional health care system by using more finely tuned and community-sensitive approaches than those available to a distant provincial government. This is certainly part of provincial governments' justification for devolving authority,[21] and it explains the assignment of resource-allocation power to the boards.

Our survey showed that three-quarters or more of board members actively used resource allocation and the other governance tools provided to them such as needs assessments, priority setting, effectiveness and efficiency measures and data. Indeed, two-thirds felt that they had enough information to make good decisions, although this information appeared to be dominated by cost and utilization data rather than documentation of benefits or citizen preferences.

Central to the creation of a health care system is the devolved authorities' ability to use these governance tools to rationalize, integrate and coordinate previously autonomous and sometimes competing services. Such rationalization can occur vertically — between institutional and community-based services — and horizontally — among institutional services (i.e., hospital mergers) or among community-based services.[27] In 2 provinces — New Brunswick and Newfoundland — the scope of the boards has been limited to institutional services, making anything other than horizontal integration of institutions difficult to achieve (although the government of Newfoundland has established separate boards for community services).

However, even in the remaining provinces, devolved authorities have tended to focus on institutions, partly because they are the largest identifiable component of their budgets but also because of 2 significant omissions from their resource-allocation power: physicians' fees and drug budgets. These 2 items constitute the lion's share of primary care resources, and it is difficult for any board to embark on horizontal integration of community-based services (or even vertical integration of community-based and institutional services) without budgetary control. As Tuohy and Evans[28] noted, governance of a sector without budgetary authority is akin to "pushing on a string."

In the provinces with two-tier structures of regional and community boards — British Columbia, Manitoba and Nova Scotia — initial confusion over relative roles and responsibilities has also hampered rationalization efforts, especially for community-based services. Since budgetary authority is usually given to the regional level, at which institutional issues predominate, hospital integration inevitably dominates concerns about rationalization. Reducing duplication and gaps among community service agencies, physicians' offices, home-care programs and so on may involve less money but is probably more challenging in the long run, given the sheer number and diversity of delivery units. This task depends to a greater extent than does hospital rationalization on local community knowledge and sensitivity. The question is whether this task can be achieved by community boards, which have minimal budgetary authority and far less information than the hospital sector. Conversely, in provinces with only re-

gional boards — Alberta, Quebec and New Brunswick — the question is whether they have enough resources and local knowledge to rationalize successfully primary care and support services within the many communities under their jurisdiction.

The main opposition to these changes is likely to come from the various provider groups and agencies whose operations are being disrupted. Provider groups have successfully mobilized opposition to several attempts at rationalization, even forcing the members of one devolved authority to resign and pass the task back to the provincial minister of health.[29] Not all boards are willing to absorb the displaced blame.

However, rebuffed rationalization tends to get far more press coverage than successful rationalization. These rebuffed attempts are concentrated in jurisdictions that continue to rely on collegial management by local professionals. Jurisdictions that exploit the capacity to blend hierarchical and collegial governance have been more willing to weather the community outcry and persist with rationalization "over the heads" of protesting providers and, sometimes, local citizens. There is clearly a tension between a devolved authority's exercise of its hierarchical governance authority, its ability to maintain provider morale and its local legitimacy as a voice of the community. Perhaps for this reason, some provincial governments (including those of New Brunswick and Saskatchewan) used *their* authority to disband hospital boards and close or downsize hospitals *before* introducing the devolved authorities.

Although it is difficult to generalize about devolved authorities, most have been able to achieve horizontal integration of some institutional services or sustain previous integration effected by the provincial government. Horizontal integration of community services and vertical integration of community services and institutions are less common, owing to structural obstacles inherent in the current design of devolved authorities and to the authorities' need to listen to local voices, which are relatively easily mobilized by threatened agencies and providers. Hence, for the boards, adopting a primary objective of community empowerment may come into direct conflict with their objective of achieving a more effective and efficient health care system. Unless professionals, agencies and institutions adopt system-oriented thinking and focus less on preserving their particular "silo," provincial governments and devolved authorities will rely increasingly on hierarchical governance to mandate a real health care system.

Reducing expenditures: blame avoidance and conflict containment

Provincial governments did not need to devolve authority to reduce expenditures on health care. Devolved authorities are, however, a convenient way to shift blame and to place a buffer between provincial governments and community discontent with fiscal retrenchment.[2] The fact that more than half of the board members we surveyed recognized this motivation is a testament to their realism; that only one-quarter felt that it interfered with their ability to make long-term plans is a testament to their optimism. Despite this optimism, the authorities' success in containing or overcoming discontent will strongly influence their ability to move forward on health care system rationalization or citizen empowerment.

Whether they planned to do so or not, many provincial governments handicapped the devolved authorities right out of the starting blocks by coupling their creation with major spending cuts. In Alberta, for instance, regional boards were expected, within 90 days of their appointment, to come up with business plans based on annual budget reductions of more than 5%.[16] This made it clear that expenditure reduction was the preoccupation.

The Alberta experience shows the danger for provincial governments of over-reliance on devolved authorities as the sponges for local discontent. If the budget is perceived to be squeezed too hard, as was the case for some regions in Alberta, then the devolved authorities can turn on the provincial government, adding their authority and legitimacy to the citizens' claims that the system is being underfunded.[30] As more provinces move to elected boards, the devolved authorities' legitimacy as lobbyists against underfunding will be increased.

As a result of this consideration, some provincial governments contemplated devolving revenue-raising powers to the authorities, although none did this.[6] This measure would have placed fiscal accountability in the local jurisdiction. It would also have reduced the legitimacy of the provincial government in determining how the health care system was to be restructured; less proportionate funding means less clout, as the federal government is discovering in regard to national standards for social programs.[31] Interestingly, only 1% of the board members we surveyed desired any revenue-raising powers for their boards.

The boards can only contain the conflict arising from provincial expenditure reductions as long as the board members feel that there is slack in the system that can be taken up with effectiveness and efficiency measures, leaving the quality of and access to care unaffected. Once the board members no longer believe that there is any slack, they are likely to leave local discontent uncontained, if not fan its flames.

More than half of the board members we surveyed stated that improving effectiveness and efficiency should be the primary objective of devolved authorities. Local discontent and conflict make it difficult to make such im-

provements. Hence, as long as board members remain convinced that there are efficiencies to be achieved, their objective and the provincial governments' desire to contain conflict will be compatible. Most provincial governments are, therefore, engaged in a careful political calculation to stay just inside the "squeal" threshold as they tighten spending. One of the new signs that they have stepped over this threshold is that the devolved authorities join and orchestrate local discontent. In other words, devolved authorities can be either a facilitator of or a brake on expenditure reductions.

Conclusions

Let us revisit the question of whether devolved authority works. First, and perhaps most important, it is difficult to generalize about the performance of 123 devolved authorities in 9 provinces. As outlined in the first article in this series, and underlined in the data presented in the second and third articles, each devolved authority arrives at its own resolution of the inherent conflict between its provincial government's expectations, providers' interests and citizens' perceived needs and wants. The chosen path of resolution tips the balance in favour of community empowerment, system rationalization or expenditure reduction, but not likely in favour of all 3 because they have elements that are mutually incompatible.

However, initial assessment suggests that most devolved authorities favour system rationalization as a primary objective and can claim some success in integrating institutions. They are tolerating the expenditure reduction requirements imposed upon them but are exchanging the role of provincial government ally for aggressive lobbyist against underfunding once such reductions exceed acceptable thresholds. Finally, they are trying hard to represent, although not necessarily empower, their communities.

Progress in integrating and coordinating the system beyond rationalization of institutional care will be difficult if the boards are not given broader budgetary authority, including at least physicians' fees and drugs as well as perhaps some social and other human services such as those included in Prince Edward Island's reforms. Even with this expanded scope, devolved authorities may still struggle to bring to reality the widespread rhetoric about the importance of the broader determinants of health, especially since they must maintain morale among their providers as they absorb expenditure reductions.[8]

The future of citizen governance and empowerment is intimately tied to the issue of elected boards. The current appointed boards appear to be well intentioned in representing and being accountable to the entire community. Whether this accountability will break down into representation of and accountability to specific interest groups will depend on whether electoral turnout is large and representative enough to affirm community-wide interests. The turnout in Saskatchewan's direct elections, held in the fall of 1995, was 35% on average and substantially less in urban areas. This does not bode well for citizen representation. As Tuohy and Evans[28] note, "A mandate drawn from substantially less than 35% of the voting population does not constitute a very effective political resource in dealing with cohesively organized provider groups."

These unknowns underline the importance of evaluating the effect of devolving authority on at least the previously mentioned objectives as well as on other objectives unique to particular provinces. The only jurisdiction in which such an evaluation is being undertaken is Prince Edward Island. The System Evaluation Project in that province is a partnership between the provincial government and Health Canada designed to generate national policy learning about devolved authority for health and to effect provincial mid-course corrections.[32] The actions of the Ontario government will offer an interesting natural experiment; they involve centralizing authority for the health care system rather than devolving it.

There is also a need for periodic gatherings at which the 123 devolved authorities can learn from each others' experiences.[14] Whether or not devolved authority for health care turns out to be a good overall policy for Canada's provinces, there are now 123 instead of 10 provincial opportunities for cross-jurisdictional learning.[33] There must be many innovations and opportunities to learn from all of that diversity.

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