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# ISSUES IN THE GOVERNANCE OF INTEGRATED HEALTH SYSTEMS

## *EXECUTIVE SUMMARY*

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PROJECT PS-002-05

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This summary is provided in both official languages. The full report is only available in English.

## EXECUTIVE SUMMARY

This policy synthesis has three basic goals: (1) to grasp the significance of governance issues as they are experienced—or could be experienced—in *integrated health care systems*; (2) to clarify the meaning of those issues so that public officials or policy-makers will be able to better address them; (3) to guide the selection of preferred models from a range of possible options, based on criteria suggested by the literature and the practitioners.

This study is not about governance in general, but about governance in a specific context: that of the creation and the operation of a special type of health care networks, generally known as *integrated health systems* (IHSs). The study of IHSs deals with issues related to the design and activities of those systems—such as the scope of services and the size of the population covered—whereas governance is concerned with the relationships between sets of actors as they create and operate IHSs.

In the last ten years, the concept of governance has been used extensively in scientific literature and in public discourse resulting in a proliferation of definitions. For the purposes of this paper, we have restricted our definition of governance *to depict the manner in which decisions are taken and implemented in social or administrative networks*. While the governance literature is preoccupied with problems arising at the local or organizational level (i.e., “micro” level) we identify and address multiple levels of governance (i.e., “meso” and “macro”) drawing attention to the policy issues and problems associated with each level.

From our standpoint, there are two key issues that policy-makers must resolve as they draft plans for the governance of IHSs: (1) the degree of autonomy each IHS will have in matters of services, budgeting, personnel, enrollment, etc.; (2) the balance in each IHS between the values and interests of direct or *internal* stakeholders, like the health care providers, and the values and interests of *external* stakeholders, i.e., the community at large. “Good” governance of IHSs implies some choices over these key issues, conducive to a balanced organization.

### Degree of Autonomy

With regard to autonomy, in prescribing governance structures three objectives must be addressed that deal with the degree of centralization in an organization: clarity of purpose; unity of command and accountability. *Clarity of purpose* is difficult to achieve within complex organizational environments such as IHSs where organizational networks are prone to competing interests struggle to have their vision to triumph over others. One way to improve things is to consider the political “center” of the network—whether it is a board, committee or regional assembly—as a forum to identify and solve problems, rather than a place where resources are allocated.

With respect to *unity of command*, governance is built around the principle that the decision point should be put where the work is performed, and that several layers of management are more a nuisance than a necessity. It is our view that approaching problems with those who perform the tasks and who will use the output will produce better and more effective decisions.

With respect to *accountability*, different levels of accountability have been identified in networks: downward to clienteles, upward to ministers and parliament, and horizontally to peer and reference groups. To render such a complex arrangement feasible, three principles must be respected:

- *Relevance*—i.e., the nature and scope of the IHS's operation should be in the hands of the people it serves.
- *Public control*—i.e., some degree of political control by elected authorities must be maintained, for example in the process used to establish an IHS or in the process used to review and sanction its performance.
- *Self-administration*—i.e., managers of the IHS should have a free hand in determining how they will run it, especially in matters of budgetary and personnel policies

### **Balancing the Range of Concerns**

In the case of balancing the values and interests of stakeholders, to achieve the goals of maximum interaction among participants, flexibility, impartiality and representativeness, we recommend a specially appointed or elected body with mechanisms built in to communicate directly with specific groups on an “as needed” basis. With respect to internal stakeholders, while we would not rule it out as a governance model we do not believe that the direct involvement and full control of internal stakeholders is an absolute requirement in the overall governance of IHSs. This is a requirement, however, in the areas of clinical governance (e.g., quality improvement, accountability). Regarding external stakeholders, the development of an effective organizational partnership requires the support of the broader community it is serving. Participation in the governance process should give those affected a real impact on the decisions, enhancing not only their influence but also their understanding of the complexity of decision-making processes.

### **Towards Good Governance**

We recommend a pluralist approach to designing models of governance since it is too early in the history of IHSs to advocate for one model over another. Within a pluralistic system, however, we strongly recommend the need for some co-ordination mechanism between models, particularly if they are run in parallel within the same geographic territory, serving overlapping populations. This would take the form of a centralized governance structure that would serve the interests of the community as a whole while preserving the autonomy of individual IHS governance structures.

In the context of this pluralistic approach we recommend an approach to designing governance models for IHSs that incorporates the following characteristics:

- At the micro level of individual IHSs, board will conduct detailed oversight and monitoring of the operations of the component parts.

- At the regional or meso level, a single board coordinates the different networks (or IHSs) active in the region. This board would have to oversee and evaluate the performance of each IHS, and verify that it is meeting accepted standards.
- At the macro level, a governance structure would set broad standards such as funding and capitation policies, quality indicators, or entitlement principles.

We recommend that the following principles apply especially to the formation of boards at the meso level:

- Preference for appointed members over elected members is overwhelming, in the specialized literature as well as in the opinions of key informants. The only question is whether appointments should be made by central authorities, by the board itself, or both ways.
- Inclusion of public representatives on the board, selected from persons already active in the community, but not necessarily from the health sector.
- The autonomy of health organizations is better respected if the board comprises some persons designated by these organizations. It is suggested that each individual IHS designates a “lead organization” inside its own network, with the purpose of representing its interests at the regional level.
- Preference for medium-sized boards. A board of fifteen to twenty members is considered reasonable, at least for the regional governance structure. Committees could be put in place to meet the necessity of consulting with particular stakeholders, like physicians or local authorities, or to create special arenas to explore policy options.

To synthesize the experiences to date with governance of IHSs, we reviewed the salient features of eleven actual and proposed models of governance and organized them into four “families of IHSs”. These governance models were then assessed against our principal criteria of good governance:

- The autonomy granted to the governance structure of each IHS and the balance of the range of concerned interests and values.
- The degree to which governance models fit within a list of criteria formulated to evaluate their effect on the performance of IHSs (i.e., population health, integration, continuity of care, incentives).

Using our assessment tool, only five of the actual and proposed models considered in our analysis have the core elements necessary for inclusion in the category of “good” governance. Although the empirical data do not point to the implementation of a particular governance model in a specific social or geographical setting it is our view that some models are more appropriate in some context than others. Health cooperatives, for example, have greater potential to become core organizations where cooperation has been traditionally used as a tool for collective action, as is the case in rural communities. In suburban areas, provider driven models would appear more logical, as they are in harmony with prevailing social and cultural conditions.