OHA

ONTARIO HOSPITAL ASSOCIATION

Hospital Governance and Accountability in Ontario

A REPORT FOR THE ONTARIO HOSPITAL ASSOCIATION

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CHAPTER 1: Introduction

For many years, hospitals in Ontario have benefited from the enormous contribution of volunteer time, energy, talent and philanthropy by the members of their Boards of Directors/Trustees. At the present time almost 3500 individuals across Ontario are providing leadership and guidance as hospital Directors/Trustees and serving as a critical link between the hospital and the communities served. However, consistent with the dramatic changes related to contemporary health care delivery, Boards are facing significant challenges in the pace of change, the growing complexity of health issues they must address and the place of their hospital within the broader health care system. In this environment, it is timely for Hospital Boards to reconsider their governance practices. Unless Board members have a full understanding of how these changes impact on their roles, responsibilities and accountabilities, they will be unable to develop the relevant efficient, "user friendly" governance processes and tools essential to support them in governing effectively.

In the *Strategic Directions for the Ontario Hospital Association 2004-2007*, one of the four strategic priorities is to "lead excellence in health care governance and promote a culture of shared accountability."[1] As a result, the Ontario Hospital Association (OHA), with the support of the Ministry of Health and Long-Term Care (MOHLTC), commissioned this discussion paper as a starting point for a process of governance renewal in the Ontario hospital sector.

Specifically, the policy directions that the OHA wishes to pursue are:

> "To increase joint accountability with government by setting and monitoring wait times, clearly defining and reporting on the level of health and hospital services available in communities throughout Ontario;
>
> To play a leadership role in advancing and promoting governance best practices in Ontario, including enhancing education programs."

The four strategies for this strategic direction are to:

1. Identify and advance health care governance best practices
    - identify and share best practices in governance;
    - renew OHA's Health Care Trustee Institute;
    - examine OHA's own governance practices.
2. Develop and promote initiatives that will result in greater joint accountability for government and providers, including accountability frameworks.

[1] Ontario Hospital Association, *Vision and Strategic Directions for 2004-2007*, (2004).

3. Support initiatives that will result in greater accountability of the community-at-large in how they access the health care system and what they expect of it.

4. Continue the development of hospital and system performance reporting."[2]

The initiative of the MOHLTC and the OHA in commissioning this discussion paper and the current Joint Policy and Planning Committee (JPPC) work underway to develop performance agreements[3], are constructive measures implemented in recent months to advance governance and accountability in the system. They also signal that the current structures are wanting and without substantial voluntary reforms in governance and accountability, involuntary reforms with uncertain consequences will likely occur.

As there is currently only anecdotal information on governance reviews and best practices in governance among Ontario hospitals, neither the MOHLTC nor the OHA has a clear picture of the state-of-the-art in hospital governance in Ontario. Governance renewal has indeed been undertaken in recently amalgamated hospitals and hospitals under supervision.[4] However, it is not known how many other hospital Boards have carried out a fundamental review of their governance processes and few have fully debated the concept of accountability as it applies to hospitals in our health care system. For an independent hospital system to remain strong and maintain public confidence, all hospitals must ensure that they have fully addressed and implemented the current essentials of good governance.

In view of these concerns, the OHA and the MOHLTC asked us to draw on their experience and our experience in working with hospitals and health organizations in developing governance and accountability frameworks. This paper, therefore, addresses best practices and recent experience in hospital governance structure and process and the key elements of hospital and government accountability. It is intended to serve as a foundation for the OHA to support its members to begin a process of governance renewal and the establishment of clear mutual accountability between government and the hospital sector. These measures will advance the effective delivery of affordable, quality health services.

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[2] *Ibid.*

[3] *Supra* note 17.

[4] Recent governance reviews include Toronto East General Hospital, Hamilton Health Sciences, Sudbury Regional Hospital, London Health Sciences, Quinte Healthcare, Guelph General Hospital.

CHAPTER 2: The Evolution of Hospital Governance in Ontario

1. Changing Demands and Expectations of Hospital Boards

The function of Ontario's hospitals and the effective delivery of patient care have altered radically since the introduction of hospitalization and Medicare. The provision of quality hospital services today requires the co-operation and co-ordination of all providers and institutions if Ontarians are to have the full advantage of modern skills and technology provided in a safe and efficient environment. Quality care also requires much greater co-operation and co-ordination between hospitals and other health service providers who share in the provision of a continuum of care for an increasing number of individuals with complex, multiple and chronic needs. These realities dictate that there must be dynamic change in the business culture of both the MOHLTC and the province's hospitals if patients are to receive the best care for the resources available.

The competing expectations of quality care, efficiency, responsive service, ready access, fairness and provider morale are a reality in all hospitals. These expectations provide significant challenges, not only for health service providers, but also for hospital Boards of Directors/Trustees (hereinafter "Directors") who have an unprecedented need for sound governance structures, policies and processes and well-understood accountabilities.

Historically, many hospital Boards in Ontario focused on raising money locally and advocating for provincial funds as their principal preoccupations to ensure that the needs of their institution were met. Today, most hospital Boards have delegated fundraising to dedicated committees or to hospital foundations. On the advocacy side of the equation, it has not been uncommon for hospital Directors to assume the role of community advocates for the hospital in pursuing more resources from the government. Indeed, it has been a long-standing attitude of some hospitals that they should assess their needs and then expect the government to meet them. This approach tends to place the focus on demand and lessen the pressure on performance and performance measurement.

Against this background, hospital Boards across Ontario are struggling to develop a clear understanding of what constitutes an appropriate balance between community advocacy for more money and services, the monitoring institutional management and performance and ensuring financial accountability to the MOHLTC.

In the 1992 report of the *Public Hospitals Act* Review, considerable attention was focused on the need for clear definition of hospital accountability "to its patients, the public and the government" and the need for "all hospital Boards and other stakeholders [to] have a common understanding of what is meant by hospital governance and of the distinction between governance and management"[5]. While the report contained a series of strong recommendations on the approach to renewal of the *Public Hospitals Act* including its governance provisions, it remains largely unimplemented today.

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[5] Ontario, Steering Committee, Public Hospitals Act Review, "Into the 21st Century: Ontario Public Hospitals Report of the Steering Committee, Public Hospitals Act Review" (February 1992) at ES-3.

Only in the last decade has governance been developing as a priority issue in health care.

Timeline	Event/Activities and Commentary
Early-Mid 1990s	- Voluntary reviews within Ontario to examine and update hospital governance in Ontario as part of DHC-led hospital restructuring initiatives. - The process led to a few voluntary amalgamations of hospitals to better serve their communities.
1996-2000	- Establishment of the HSRC. The HSRC issued Directions to require hospital amalgamations and/or the acquisition of one or more hospitals by another. - The HSRC provided considerable latitude to the amalgamating hospitals in developing new governance structures subject to ensuring that Board composition was structured to reflect the diversity of the community served and that members of the new Board have relevant experience and expertise[6]. - This coming together of hospitals challenged the individual independence of those hospitals and they found it necessary, as part of the amalgamation process, to work together to use the instruments of governance to provide assurances that the communities served by the amalgamating entities would continue to be appropriately served. - While a number of useful innovations in governance policies and practices were introduced during this period, the focus was on the assurance that affected communities would not suffer and little, if any, attention was paid to defining accountabilities beyond community guarantees. Further, the incentive to address by-law renewal was confined largely to those hospitals with major HSRC directions, and consequently, the usual precedents for hospital governance remained largely unchanged in many of the unaffected hospitals.
Post HSRC Today	- While most of the new hospital corporations did establish comprehensive governance policy frameworks including Board and individual Director roles and responsibilities, guidelines for the selection of Directors, committee structures, etc. prior to amalgamation, several of the amalgamated hospital corporations have recently initiated a process of governance renewal in which they are revising their governance policies and processes and focusing on the accountability of the Board, which was not a primary consideration at the time of amalgamation.[7] - While new hospital by-laws were subject to legal approval by the MOHLTC, to date, the Ministry has not taken a corporate interest in the emerging governance structures arising from restructuring, as an opportunity to profile best practices for the broader hospital sector.

[6] The Ontario Health Services Restructuring Commission, "Looking Back, Looking Forward: A Legacy Report" (March 2000), online: Canadian Health Services Research Foundation <http://www.chsrf.ca/other_documents/outside_publications/index_e.php> at 44.

[7] Examples include Sudbury Regional Hospital, Quinte Healthcare and Toronto Rehab.

1997-2002	- 22 operational reviews conducted at hospitals in Ontario. - This experience served as a catalyst to focus significant attention on the need for joint accountability between the MOHLTC and Ontario hospitals, a need which was originally identified by a joint committee of the OHA, hospitals and MOHLTC in 1988. - Consequently, the three parties convened the Joint Accountability Task Force in 1999, with a mandate to develop an accountability framework including the respective roles, responsibilities and mutual obligations of the Ministry, the OHA and the hospitals. To date, the recommendations of this group have not been implemented.[8]
1998	- The Canadian Council on Health Services Accreditation (CCHSA) and the Canadian Comprehensive Auditing Foundation (CCAF) [9] developed a series of tools for "Governance Check-up" to assist governing bodies of health care organizations to assess their performance in relation to the 15 accreditation standards for governance, established by the CCHSA.
2002-2004	- Implementation of Governance Reviews by a number of Ontario Hospitals either as part of Supervision or locally initiated.[10]
2003	- Joint Policy and Planning Committee initiative on Performance Agreements in the Hospital Sector.
2004	- OHA Strategic Directions to "lead in advancing excellence in health care governance and promoting a structure of shared accountability"

2. Weaknesses in Governance and Accountability

Hospitals

A series of events have challenged the state of hospital governance in Ontario. Rapidly growing deficits, combined with concerns about the effectiveness of Board governance, led to a series of Operational Reviews**,** the appointment of Provincial Supervisors, Fact-finders, Investigators and the Third Party Review to examine the facts giving rise to these circumstances. Frequently cited flaws in hospital Board governance were:

- lack of clarity with regard to the Board's respective accountabilities to government and their communities;

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[8] Ontario Hospital Association, *Report from the Task Force on Operational Review and Supervisor Appointments,* (January 2004) at 1-2.

[9] Canadian Council on Health Services Accreditation and the Canadian Comprehensive Auditing Foundation, *Governance Check-up: Guidance for Health Care Organizations: Issues, Responsibilities, Actions,* (1998).

[10] See note 5.

- lack of consistent understanding of the Board's roles and responsibilities;
- lack of the appropriate mix of skills within the Board to fulfil the full scope of governance responsibilities;
- infrequent Board-member turnover resulting from a lack of defined limits on terms of office for Directors/Trustees and officers;
- inadequate and/or inappropriate information to support the Board in making informed decisions;
- absence of formal Board policies, processes and/or systems to support the Board in fulfilling its governance roles and responsibilities;
- lack of alignment between Board roles and responsibilities and the processes for conducting the work of the Board;
- inconsistent approaches to Board orientation and continuing Board education;
- Board committee structures that reflect a lack of clear differentiation between governance and management responsibilities.

MOHLTC

In parallel with the challenges faced by the hospital Boards, the Ministry of Health and Long-Term Care (MOHLTC) has been and continues to be faced with cost escalations that are unsustainable, while struggling with less than viable management information to guide change. Consequently, for its part, the MOHLTC has tended to focus on managing and containing the financial demands of hospitals, while doing little to provide leadership in formulating governance policies or providing the support systems basic to good governance and accountability, such as better information systems and clarity in funding programs.

Given the way the system has evolved, these are natural and understandable behaviours by the hospitals and the MOHLTC. They do not, however, advance the fundamentals of ensuring that every health dollar is being spent in an optimal manner to provide effective, quality health care. This situation is not unique to Ontario. The BC Auditor General, in his review of Performance Agreements found that decision-making authority between government and hospitals has long been clouded.

> "This uncertainty in decision-making authority is evident across Canada. According to a national survey of board members, CEOs and senior managers in health ministries, the majority confirmed that the division of authority between health authorities and ministries is not clear…. The analysis behind this survey found that clarity does not evolve naturally over time, and the ministry and health authorities will need to make a concerted effort to improve it."[11]

[11] *A Review of Performance Agreements Between the Ministry of Health Services and the Health Authorities*, 2003/2004: Report 1, Office of the Auditor General of British Columbia, at 20.

The Public

Public attention to health care has never been greater than it is today, following both the Romanow and Kirby reports. Canadians are looking for action. Sustainability of the publicly funded health care system has been the major preoccupation in debates on the future of the system for most of the past decade. In recent years, the inflow of dollars into the system has been considerable. Whether more money can or should be available, it is essential that the problem be recognized as much more than a government funding problem.

Canadians are proud of what we have accomplished as a nation in providing care for each other and are acutely aware that the system is falling short of our needs and aspirations. The growing emphasis on governance and accountability is recognition that collectively we are not doing enough to ensure that we are getting full value from the system as it is currently configured. For the public to be assured that its investment in its most cherished government program is being efficiently and effectively utilized to advance their health services, it is incumbent on all parts of the system to establish sound governance and accountability practices.

3. The Challenge to Independent Hospital Governance

The above pressures have placed enormous stress on the relationship between the MOHLTC and hospital Boards. These pressures, in turn, have clouded and strained the governance and accountability relationships between both parties, resulting in much frustration and finger pointing.

These circumstances and others which have been bubbling beneath the surface for some time clearly influenced the introduction of Bill 8: The Commitment to the Future of Medicare Act (2003) by the Minister of Health and Long-Term Care on November 27, 2003. The implications of the Bill for independent hospital governance are considerable. With integration and system co-operation being foremost considerations of the Minister, the hospitals must act and be seen to act on governance.

Hospitals will be aware of a significant precedent for direct government intervention in voluntary health sector governance in the enactment of Bill 130[12], which transformed Community Care Access Centres (CCACs) to Statutory Corporations with Order-in-Council appointed Boards and Executive Directors in 2001. It must also be recognized that the process of regionalization in most provinces has resulted in the replacement of voluntary locally elected hospital Boards with government appointed Regional Health Authorities.

The intention of the government to have the provincial auditor audit the hospitals in the province under Bill 18[13] and the establishment of performance agreements between the MOHLTC and the individual hospitals under Bill 8 could also impact on the future independence of hospitals. In his

[12] Legislature of Ontario, Bill 130, *Community Care Access Corporations Act*, 2001

[13] Legislature of Ontario, Bill 18, *The Audit Statute Law Amendment Act*, 2003

2003 Annual Report, the Provincial Auditor reported on the potential impact of the intention of the government to prepare its financial statements in accordance with principals recommended for governments by the Public Sector Accounting Board.

In the section of the Report entitled The Government Reporting Entity, the Report states:

> "One of the most critical aspects of reporting on a government's financial affairs is deciding which organizations – from among, for example, ministries, agencies, Crown-controlled corporations, Board, commissions, and organizations receiving transfer payments – should be included in the reporting entity. Inclusion in the reporting entity essentially means that the organization's operating results and its assets and liabilities are consolidated with or otherwise incorporated into the government's financial statements…"[14]

Currently, hospitals are not part of the reporting entity of government. In the analysis in the report, a number of factors are considered that might lead to hospitals being considered part of the "reporting entity".[15]

In a forthcoming paper prepared for the OHA, the author concludes that the combination of Bill 8 and 18

> "…reinforces the notion that hospitals will be "controlled institutions" with reduced autonomy for their administration, governance and management."[16]

While there is agreement in principle that performance agreements and hospital audits by the provincial auditor are appropriate, it is important to note that the consolidation of the hospitals operating results, assets and liabilities in the government's financial statements would result in the de facto loss of hospital corporate independence as the government would be seen to be directly accountable for hospitals as it is currently with ministries.

It would also have the disadvantage of having the conflicting roles of funder, insurer and provider under single control.

As the MOHLTC continues to support independent hospital governance, the principal message is that the hospitals and the MOHLTC, in the negotiation of the performance agreement, must ensure that they do not include PSAB control indicators that would result in the loss of the corporate independence of the hospitals.

Clearly these circumstances underline the need for measures to be taken by the OHA to "get ahead and stay ahead of the governance/accountability curve" by initiating a series of actions to assist member hospitals. These measures should be taken in co-operation with the Ministry, as

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[14] Provincial Auditor, *2003 Annual Report of the Office of the Provincial Auditor*, Chapter 5, (2003) at 362.

[15] *Ibid.* at 363-5.

[16] Jean-Pierre Boisclair FCA CMC, *From Accountability to Control*, paper prepared for the Ontario Hospital Association.

the active support and participation by the Ministry is essential to solving the problems of hospital governance. This is particularly timely as both the OHA and the MOHLTC have identified governance renewal as a strategic priority and taken the initiative through the Joint Policy and Planning Committee (JPPC) on multi-year funding and a performance agreement consultation process. [17]

4. Broader Health System Reform

The current challenge to hospital governance and accountability is made even more complex by the emerging MOHLTC expectations of hospitals in the context of the broader health system. It is clear from recent statements of the Minister on "transformation" of the health system[18] and the introduction of Bill 8, that hospital Boards in Ontario (as well as other health service providers) are on the threshold of significant new challenges and expectations of the way they are organized and do business, both internally and in relation to each other.

The Minister has made it clear that while independent voluntary hospital governance will be maintained, there will be a significant increase in MOHLTC expectations of hospital Boards with respect to accountability, joint planning with other health service providers and service integration. In his presentation to the Standing Committee on February 16, 2004, Minister Smitherman underlined the importance of the flow of accountability through Board governance:

> "The Ministry would establish accountability agreements with the Board of Directors. And the Board is then required to establish a similar performance agreement with the CEO. We will be introducing amendments, which will clarify the process for entering into accountability agreements.
>
> Accountability agreements would ensure targets are met in key deliverable areas such as access, quality, and safety. There are provisions that would link compensation with key deliverables, and we would expect the Board to hold its CEO accountable for failure to meet deliverables.
>
> The intent here is not to take away any of the authority of the governing executive Boards, but to clarify our expectations for deliverables."[19]

The Minister's statement leaves no doubt that not only will performance agreements be required, the expectations of system co-operation will go beyond the traditional walls of the hospitals.

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[17] Joint Policy and Planning Committee, *JPPC Multi-Year Funding and Performance Agreement Consultation Process December 2003*, (December 2003).

[18] The Honourable George Smitherman, Minister of Health & Long-Term Care. Address to the Economic Club of Toronto *Transforming Ontario's Health Care System* (24 February 2004).

[19] Bill 8: The Commitment to the Future of Medicare Act "Remarks by George Smitherman Minister Of Health and Long-Term Care To the Standing Committee For Commencement of Bill Eight Hearings" (16 February 2004), online: Ontario Ministry Of Health and Long-Term Care <http://www.health.gov.on.ca/english/media/speeches/archives/sp_04/sp_021604.html>.

"Too often health providers are working in isolation, losing opportunities to share information and to work in a complementary way. It's time to actually transform our health care system into a "system"."[20]

5. Implications for Governance and Accountability

The increasing governance pressures on Ontario hospitals and emerging directions in broader health system reform have implications for Hospital Boards and the Ministry of Health and Long Term Care including:

- an unprecedented focus on the need to better define the role of governance and the mutual accountabilities of the Hospital Boards and the Ministry of Health and Long-Term Care
- the need to clearly define and differentiate the Hospital's accountability to the MOHLTC and community;
- resolution of the parameters and processes for execution of accountability/performance agreements, which will form the contractual agreements between the Ministry and individual providers or groups of providers;
- a critical assessment of the alignment of individual hospital governance structures and processes with best practices;
- the need to reframe the understanding of governance as expanded beyond the individual institution to include shared accountability among providers for patient/focussed clinical service integration and efficiencies in administrative and support services within the local or regional health system;
- new mechanisms for dialogue among Boards and CEOs;
- the need for new governance structures and formal agreements to facilitate shared services among hospital Corporations and/or between hospitals and community providers.

[20] *Ibid.*

CHAPTER 3: Critical Elements of Effective Hospital Governance: Structure

A. Corporate and Fiduciary Obligations

The hospital is a Corporation without share capital (a "not-for-profit corporation") established under the *Corporations Act* (Ontario) (the "*Corporations Act*"). The rights, duties and powers of Directors and Boards of Directors are set by provisions of the *Corporations Act* and the hospital's constating documents, including the *Public Hospitals Act*, any private legislation or by-laws. The legislation sets minimum standards of performance to be met by the directors.

Fiduciary Duties

Directors of not-for-profit corporations are viewed as fiduciaries to the Corporation and, as such, are held to a high standard of conduct. As fiduciaries, Directors owe the following duties to the not-for-profit corporation:

- the duty to act honestly;
- the duty to act loyally and avoid conflicts between the Director's personal interests and the interests of the Corporation. Directors must therefore act in complete good faith and disclose all conflicts of interest to the Corporation;
- the duty to keep the Corporation's information confidential;
- the duty to act in the best interests of the Corporation and its members as a whole, and not in the interests of any particular member;
- the duty to act in accordance with the expected standard of care

Directors of not-for-profit corporations are subject to the same basic duties of "stewardship" imposed on directors of business corporations.

Directors of a not-for-profit corporation must meet a minimum standard of care, which is subjective in nature, and therefore varies from Director to Director. A Director must exercise a degree of skill that may be reasonably expected from a person of his or her knowledge and experience. Directors of a not-for-profit corporation may be shielded from liability where they have made a decision with due care and on the basis of all material information reasonably available, if the decision was made honestly and in the best interests of the Corporation.

Directors must act at all times in the best interests of the hospital. These best interests include the best interests of its members. The Directors must generally consider the members' interests as a group, not the special interests of a particular member or group.

As the 1994 Toronto Stock Exchange Report on Corporate Governance stated:

> "Directors must be scrupulous in identifying what they regard as the best interests of the Corporation or of shareholders generally, whether this interest conflicts with or coincides with the best interests of a particular shareholder. A Board of Directors is not a parliament where elected members represent the best interests of their constituency. Directors have only one constituency and that is the Corporation and its shareholders generally".[21]

Within the context of the hospital sector, while advocacy is a legitimate role in certain circumstances, it is not in itself a justification for holding the position of Director. A Director's primary responsibility to the Corporation necessitates assurance to the members of the Corporation that the hospital is well-managed, efficiently run, patient-oriented, achieves acceptable outcomes, etc. The Director's duty to the community is not only to pursue more money from government, but also to assure government and the community that the hospital is providing the best care possible within the resources provided. This assurance must be based on solid evidence. With quality evidence in hand, the Director can then see the advocacy role as legitimate. Advocacy without strong evidence undermines the stewardship obligations of the Board to manage what amounts to a public trust.

B. Governance Policy Framework

Best practices in governance literature and actual experience from selected hospitals in the province suggest that critical elements of an effective hospital governance policy framework should include:

- Principles of Governance and Board accountabilities;
- Roles and responsibilities of the Board of Directors;
- Roles and responsibilities of individual Directors;
- Guidelines for the selection of Directors, including generic qualities required in all Directors and the range of specific skills and expertise required within the Board as a whole;
- Board size and composition which is optimal for effective functioning;
- Terms of office for Directors and Officers which facilitate succession planning and renewal within the Board;
- Board Standing and Ad Hoc Committees which are streamlined to support the Board to fulfil its responsibilities;
- Corporate membership which provides a meaningful opportunity for the community to engage with the hospital.

[21] The Toronto Stock Exchange, *Where were the Directors?, Guidelines for Improved Corporate Governance in Canada, Report of the Toronto Stock Exchange Committee on Corporate Governance in Canada (the Dey Report),* (December 1994) [archived at The Toronto Stock Exchange].

The following is a brief discussion of the central considerations in relation to each of the components.

1. Principles of Governance and Board Accountabilities

Principles of governance are initially established by the Board to address its overall philosophy and approach to its governance responsibilities. An important part of establishing the principles of governance is the examination of the range of governance models which could be utilized by the Board and a deliberate decision as to the model which is best suited to the organization at the particular stage of its evolution.

In the past decade, the Carver Policy Governance model[22] has been widely used within the hospital sector in Ontario. More recently, as Boards have become increasingly concerned with their oversight responsibilities, the Pointer and Orlikoff model[23], which we have adapted as the "Hybrid Policy Leadership" model, has become increasingly attractive to a number of hospital Boards and other health care provider organizations in Ontario. The details of this model will be described in (2) Board Roles and Responsibilities. However, the overall characteristics of this model are:

- clear differentiation between governance and management while recognizing interdependencies;
- Board is focused on providing strategic leadership and direction;
- Board establishes policies, makes decisions and monitors performance related to the key dimensions of the organization's business as well as its own effectiveness;
- Management is focused on development of policy options, appropriate reports to support decisions and monitoring by the Board and management of operations consistent with Board policy;
- small number of Board Committees tied to key governance responsibilities;

The Principles of Governance should ideally include:

- a statement of the Board's fiduciary obligations to act in the best interest of the Corporation;
- a statement of the Board's accountabilities to its patients, the Ministry of Health and Long-Term Care and the communities served;

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[22] John Carver, *Boards That Make a Difference: A New Design for Leadership in Nonprofit and Public Organizations*, (San Francisco: Jossey Bass Inc., 1990).

[23] Denis D. Pointer & James E. Orlikoff, *Board Work: Governing Health Care Organizations*, (San Francisco: Jossey Bass Inc., 1999).

- the model of governance which the Board is using (i.e., policy governance, hybrid policy leadership or other);

- provisions with respect to transparency and the approach to decision-making.

Recently, several Ontario hospital Boards have further articulated their understanding of their accountabilities in a formal "Director's acknowledgement."[24]

2. Roles and Responsibilities of the Board of Directors

There is no consistent approach among hospitals in defining Board roles and responsibilities. The legislative foundation of the Board's role as defined in the *Public Hospitals Act* is "to govern and manage the affairs of the Corporation[25]. The responsibilities of the Board are further elaborated in Regulation 965 (Section 2). However, the scope of responsibilities as outlined in the Regulations is limited to monitoring performance for compliance with the *Public Hospitals Act*, appointment of the Chair of the Medical Advisory Committee and emergency procedures.

In re-defining roles and responsibilities in recent years, hospitals have been guided by a variety of sources including:

- *Public Hospitals Act* Review, 1992;

- Toronto Stock Exchange; Where Were the Directors? 1994;

- Broadbent Report of the Panel on Accountability and Governance in the Voluntary Sector, 1999;

- Canadian Council on Health Services Accreditation (CHSA) and the Canadian Comprehensive Auditing Foundation Governance Check-up: Guidance for Health Care Organizations, 1998;

- OHA/OMA Prototype Hospital By-laws, 1990 and 2003;

- Governance experts including Carver and Pointer and Orlikoff;

- Advice and precedents provided by governance facilitators and legal advisors.

In our recent work with hospital Boards, we have concluded that the greatest clarity in Board roles and responsibilities is found in the Pointer and Orlikoff model which clearly differentiates between Board roles and Board responsibilities[26]. Specifically the Board roles include:

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[24] These include Toronto East General Hospital, Sudbury Regional Hospital and Halton Healthcare Services.

[25] R.R.O. 1990, Reg. 965, s. 2(1).

[26] Adapted from *supra* note 23 at 30-1. This framework has been used to develop the Board Roles and Responsibilities by Toronto East General Hospital and the Sudbury Regional Hospital.

- ***Policy, Formulation*** – establish policies to provide guidance to those empowered with the responsibility to manage Hospital operations.

- ***Decision-making*** – choose from alternatives which are consistent with Board policies and that advance the goals of the Hospital.

- ***Oversight*** – monitor and assess organizational processes and outcomes.

The Board responsibilities include:

- ***Defining Ends*** – identifying key stakeholders; establishing the vision, mission and core values; contributing to the development of and approval of the strategic plan; ensuring that key goals are formulated in annual operating plans; monitoring performance against the strategic and operating plan; retaining overall accountability for the performance of the hospital.

- ***Providing for Excellent Management*** – select the CEO and Chief of Staff/Chair of the MAC; establish measurable annual performance expectations; delegate responsibility and authority and require accountability to the Board; appraise/assess performance annually; provide for succession and ensure that CEO and Chief of Staff/Chair of the MAC establish a succession plan for management, professional staff and allied health workers.

- ***Ensuring Program Quality and Effectiveness*** – credential professional staff; ensure quality goals and performance indicators are developed for approval of the Board and monitor indicators of clinical outcomes and quality of service; ensure processes are in place for identifying, monitoring and managing risks.

- ***Ensure Financial Viability*** – ensure that key financial objectives and indicators are developed for approval by the Board and monitor performance against these objectives; approve the annual operating plan; ensure optimal utilization of resources and operation of the organization within its resource envelope; ensure organizational undertakes financial planning for effective resource allocation.

- ***Ensure Board Effectiveness*** – establish policies re Board structure and processes to maximize the effective functioning of the Board; measure the effectiveness of Board and individual directors through annual evaluation process; provide for succession planning of directors and officers.

The following matrix[27] illustrates the relationship.

Conceptual Framework – Board Roles and Responsibilities *

	Policy Formulation Role	Decision Making Role	Oversight Role
Responsibility for **Ends**			
Responsibility for **Executive Management Performance**			
Responsibility for **Quality**			
Responsibility for **Finances**			
Responsibility for **Itself**			

*** Pointer, D.D., Orlikoff, J.E. Board Work: Governing Health Care Organizations. Jossey Bass, 1999.**

More recently, some hospital Boards have added a sixth responsibility of ***Building Relationships***, given the increasing expectations for the co-ordination and integration of health services and strengthened relationships between hospitals and their communities.

Among hospitals, which are seen to have effectively utilized a modified Carver approach, Halton Healthcare Services has defined its governance structure and differentiated between Board and Management responsibilities in the categories of strategic directions, operations and governance process. In relation to these responsibilities, the Board roles are defined as establishing ends, delegation to the CEO and monitoring.[28]

There is no single "right" approach to defining Board roles and responsibilities. The essential consideration is that Boards must actively debate and clearly define their roles and responsibilities using whatever precedents or templates that best meet their needs.

Governance vs. Management

One of the continuing challenges faced by every hospital Board is ensuring that it understands and clearly differentiates between governance and management. Within the context of the Board roles of policy formulation, decision-making and oversight, the perennial question is what is the "right level" of Board involvement. This balance has been particularly challenged in recent years of heightened focus on Board accountability and the oversight role of the Board.

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[27] *Supra* note 23 at 113.

[28] Halton Healthcare Services, *Governance Manual*, (2004).

In its recent report, the TSE observed

> "The Board's relationship to management is critical to healthy governance. It is a relationship that must continue to be maintained in a delicate balance. What is required is a common appreciation by management and the Board of their respective roles, a mutual respect by each party in carrying them out, continuing dialogue and communication, and strong leadership within the Board. …[The Board] must delegate authority [to the CEO] and recognize that, once authority is delegated, management must be free to manage. But the Board cannot be too accepting of management's views. It has the responsibility to test and question management assertions, to monitor progress, to evaluate management's performance and, where warranted, to take corrective action."[29]

3. Roles and Responsibilities of Individual Directors

In addition to clearly stating the roles and responsibilities of the Board as a whole, it is essential to make explicit the roles and responsibilities of individual Directors. This is necessary for two reasons: first, to enable prospective and current Directors to have a clear understanding of what will be expected of them and secondly, to have an objective benchmark against which to assess the performance of individual Directors. Typically, the matters to be addressed in the specific roles and responsibilities of individual Directors should include[30]:

- accountability including fiduciary obligations
- exercise of individual authority
- conflict of interest
- team work
- Board solidarity and confidentiality in decision-making
- expectations re the level of attendance and participation at Board and Committee meetings
- competencies including generic attributes and specific skills and expertise
- participation in Board education
- participation in Board and individual Director evaluation

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[29] The Toronto Stock Exchange, *Beyond Compliance: Building a Governance Culture*, (November 2001) [archived at The Toronto Stock Exchange] at 12.

[30] Great Boards, "Position description for a Health System or Hospital Board Member" online: Bader and Associates <http://www.greatboards.org/samples.htm>.

4. Guidelines for the Selection of Directors

In order for a Board to function effectively, its membership must consist of individuals who have both generic attributes and specific skills to support the policy formulation, decision-making and oversight processes in relation to the full scope of Board responsibilities. At the present time, there is a range of experience across Ontario hospitals in the application of a "skills" matrix to Board composition and the selection of Directors. While a number of hospitals, including most of the amalgamated hospital corporations, have moved in this direction since the mid-90s, there is still a practice among some hospitals to utilize an approach to Director selection which is based on representation of particular constituencies or interests (e.g., municipalities), which is now inconsistent with recognized best practices.

The essential problem with the "representative" approach is that it confuses the accountability of the Director who must balance the interests of his/her constituency with that of the hospital, rather than have an unencumbered ability to fulfil a fiduciary obligation to act in the best interest of the hospital. Municipally elected representatives provide a good example of this confused accountability. They are elected by municipal electors to advance municipal causes that may often conflict with the duty of the Director to the hospital corporation. In its recent Governance Review, the Governance Task Force of the University Health Network noted that

> "the representational nature of the Board creates a confusion of loyalties, which will be exacerbated by the increasing need for health care providers to forge partnerships and other alliances in order to deliver cost-effective services."[31]

Current best practices in the selection of Directors[32] emphasize the importance of hospital Boards establishing clear policy guidelines for Director selection, including generic attributes and specific skills and expertise and a systematic annual process for analyzing the current skills and expertise within the Board as a foundation for succession planning and recruitment of new Directors to fill the gaps. Once this framework is established as policy by the Board, the responsibility for implementing the guidelines and process on behalf of the Board can be delegated to a Board committee, typically a Governance Committee.

The generic attributes of Directors should be aligned with the individual Director roles and responsibilities and include such matters as:

- understanding of governance;
- ability to commit the time to participate effectively at both the Board and committee levels;
- ability to work effectively as a member of a team;
- effective communication skills;
- absence of conflict of interest which would impede the Director's participation in the work of the Board

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[31] University Health Network, *Report of the Governance Task Force*, (2002) at 14.

[32] *Supra* note 23 at 157-65.

The "Board Profile" of specific skills and expertise required within the Board, should reflect the hospital's specific needs (which will change over time) and ideally include the following:

- senior level business management experience in a complex environment
- management/professional accounting
- finance including financial analysis and forecasting, budgeting
- quality, risk management and performance measurement
- legal
- human resource management
- information systems management/ technology
- communications
- government and media/public relations
- governance
- knowledge of health care systems
- academics (research and education in teaching hospitals)
- construction design/management (may be a time-limited requirement)

Beyond the generic attributes and specific skills and expertise as outlined above, some hospitals may wish to establish policies with respect to balance within the Board to address particular demographic characteristics or geographic balances within their communities. The essential consideration is that these balance requirements be seen as secondary to, rather than in lieu of, the Board profile of skills and expertise, which should drive the recruitment and selection process.

5. Board Size and Composition

> "The issue of Board size involves a balance between two important governance effectiveness considerations. On the one hand, there is the need to ensure a proper diversity of perspectives, backgrounds, expertise and experience within a Board. On the other hand, there is the need to keep Board size sufficiently small to facilitate open and effective dialogue and the full participation and contribution of each director." [33]

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[33] PMH Foundation and the Canadian Comprehensive Auditing Foundation, "Reaching For Excellence: Governance and Performance Reporting at the Princess Margaret Hospital Foundation" (2001), online: Princess Margaret Hospital Foundation <http://www.pmhf-uhn.ca/html/publications/default.asp> at 27.

There is a significant variation in the size of hospital Boards in Ontario. Some Boards, particularly in the case of recently amalgamated hospital corporations, have in excess of 25 members. However, since the time of amalgamation, several of these Boards have reduced the number of members. The most typical range now seems to be between15-20 members, including both elected and ex-officio Directors. The OHA/OMA Prototype By-laws recommend a total of 16 Directors, including 12 elected and four ex-officio Directors.[34]

Recently, a number of hospitals have reviewed the size of their Boards, precipitated by a variety of issues including absenteeism, length of Board meetings, sub-optimal Director participation and concerns re balance between elected and ex-officio Directors. The UHN Governance Task Force noted that

> "one of the concerns about large Board size is a perceived loss of accountability by individual trustees. In addition, it is felt that the level of commitment on the part of some members of large Boards (as evidenced, for example, by their attendance habits) is lower than where the size of the Board is smaller. It was also felt that a reduction in the size of the Board would result in the Board's ability to give more effective oversight to the management of the hospital. Finally, there are administrative efficiencies to be realized in reducing the size of the Board."[35]

Reaching for Excellence noted that

> "recent surveys indicate that one of the most consistent governance trends is a paring down of Boards… There is a general view that as the number of directors on the Board increases beyond a particular threshold (approximately 20) the effectiveness of the Board decreases.[36] There are ways to extend the reach of the Board without increasing its formal membership – that is by involving non-members on some Board committees."[37]

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[34] Ontario Hospital Association, *OHA/OMA Prototype Hospital by-laws*, (2003), s. 3.1(1).

[35] *Supra* note 31 at 12.

[36] *Supra* note 33 at 21.

[37] *Ibid*. at 5.

In 1994, the Dey Report recommended that

> "every Board should examine its size and, with a view to determining the impact of the number on the effectiveness, undertake where appropriate, a program to reduce the number of Directors to a number which facilitates more effective decision-making."[38]

Pointer and Orlikoff have suggested that

> "the ideal Board (with thirteen, fifteen or seventeen members) is small enough to function as an effective deliberative body without the need for an overly active dominant executive committee. It is also large enough to create cohesive teams with an appropriate mix of skills, experience and other desired characteristics. A Board this size range is large enough to shoulder necessary governance responsibilities and roles, and also function unimpeded by the absence of several members from the meeting."[39]

The issue of balance between elected and ex-officio Directors is central to the determination of Board size. The minimum number of ex-officio Directors required under the *Public Hospitals Act*[40] is either two or three, depending on the size of the hospital:

- The Chief of Staff/Chair of the MAC
- President of the Medical Staff
- Vice-President of Medical Staff – for hospitals not having fewer than 100 beds

The OHA/OMA Prototype By-laws[41] recommend four ex-officio Directors including:

a) The President of the Medical Staff

b) The Chief of Staff

c) One Director elected or appointed by the Board from those candidates proposed by [the municipality];

d) A representative of the Hospital's voluntary association(s)

Notwithstanding these precedents, there is an emerging pattern of Boards identifying alternative ways of maintaining relationships with key constituencies such as Foundations, Volunteer Associations and Municipalities, which have historically held ex-officio positions on hospital

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[38] *Supra* note 21 at 5.

[39] *Supra* note 23 at 135.

[40] R.S.O. 1990, c. P.40.

[41] *Supra* note 34, s. 3.1(3).

Boards. This has occurred in several amalgamated hospital corporations where there are still multiple foundations, which would otherwise expect to hold ex-officio positions. It has also occurred more recently in hospitals which have critically evaluated the size of their Board and concluded that the effectiveness of the Board would be enhanced by reducing its overall size and reducing the number of ex-officio Directors to ensure the dominance of the elected Directors.[42] However, in the event that Boards of Directors determine that these ex-officio positions should be eliminated, it is incumbent on them to explain the rationale in advance to those affected, and to provide assurance of an ongoing relationship by establishing clear policies as to the specific mechanisms which will be put in place to ensure timely and appropriate ongoing communication with these organizations.

Practices among Ontario hospitals vary with respect to the status of the CEO in relation to the Board. Some hospitals do not include the CEO on the Board to ensure a clear separation between governance and management. Others include the CEO as an ex-officio non-voting member. Notwithstanding the OHA/OMA Prototype By-laws, in which the CEO is not a Director of the Board and does not hold the office of President of the hospital[43], increasingly, the practice is to include the CEO as an ex-officio voting member. Pointer and Orlikoff who strongly support the CEO as an ex-officio voting member state that:

> "when the CEO sits on a Board as a voting member, it emphasizes a key aspect of the unique relationship between the Board and the CEO. This relationship is employer-employee but also a partnership. The CEO as a voting Board member emphasizes the partnership aspect of the relationship and contributes to better governance.[44]

In addition, it is common to include a representative of University Faculty of Medicine or Health Sciences as an ex-officio Director in the case of hospitals which are Academic Health Science Centres.

6. Term of Office of Directors and Officers

There is a significant variation in terms of office among both Directors and Officers of Ontario hospitals. The *Public Hospitals Act* stipulates a maximum term of five years with no limit on the number of consecutive terms.[45] The OHA/OMA Prototype By-laws suggest a maximum of nine consecutive years of service.[46] Experience has shown that tenure in excess of this duration can impede the effective functioning of the Board in that there is often inadequate attention to

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[42] For example, University Health Network has recently reduced the size of its Board from 38 to 20 members including 5 ex-officio Directors. The Sudbury Regional Hospital has reduced the size of the Board from 20 to 18 Directors and reduced the number of ex-officio Directors from 8 to 6. In both cases, new formal mechanisms have been established to ensure regular communication with the Foundations, volunteer associations and municipalities.

[43] *Supra* note 34, s. 4.1.

[44] *Supra* note 23 at 175.

[45] *Supra* note 40.

[46] *Supra* note 34, s. 3.1(2)(c).

succession planning for both Directors and Officers and limited opportunity for the infusion of new blood, necessary skills, new ideas and renewed energy.

Pointer and Orlikoff recommend a maximum of three consecutive three-year terms to allow a new member one term to come up to speed, an opportunity for a second term to make a significant contribution to the Board and a possible third term to ascend to a position of Board leadership[47]. They also recommend that

> " all Boards should have an explicit policy that term renewal is not automatic. All Board members should be subject to an evaluation at the conclusion of each term to determine if their performance, as well as the anticipated needs of the Board, warrant their re-appointment."[48]

Key considerations in establishing the term of office include:

- the opportunity for recruitment of new members with the specific skills required at a point in time;
- the substantial commitment of personal time and effort arising from the roles and responsibilities of the Board in the current environment;
- Board membership may be more attractive to individuals who are willing to make a time-limited commitment.

In the case of Board Officers, there is, again, significant variation in the terms of Chairs and Vice-Chairs and Treasurers among Ontario hospitals. The OHA/OMA Prototype By-laws recommends a maximum of three consecutive years in one office.[49] Pointer and Orlikoff recommend a maximum two-year term for these positions with a maximum of two terms. [50] However, our experience suggests a maximum of two one-year terms in order to maximize the contribution of the Officers while at the same time providing opportunities for succession to leadership positions by other Directors.

Many hospitals have provided for the Chair to remain on the Board as past-Chair. However, this practice is also being questioned in the context of recent governance reviews. For example, the Sudbury Regional Hospital determined that the Board Chair would be expected to retire from the Board on completion of his/her term as Chair or, at a maximum, to remain on the Board for an additional year as a Director, not as Past-Chair. This is intended to maximize unencumbered leadership by the new Board Chair and to provide opportunities for recruitment of new members to the Board.[51]

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[47] *Supra* note 23 at 170.

[48] *Ibid*. at 159.

[49] *Supra* note 34, s. 4.1(4).

[50] *Supra* note 23 at 171.

[51] Sudbury Regional Hospital, By-law No. 5, *Administrative By-laws*, (December 2003).

7. Board Standing and Ad Hoc Committees

a. Board Standing Committees

The relationship between the Board and its Standing Committees is a critical element in the effective functioning of the Board.

In ***Reaching for Excellence***, it was emphasized that

> "the function of committees is to help a Board with a task that belongs to the Board… Considerations on the need for and operation of Board Standing Committees include:
>
> - Is the committee focusing on a matter in which the Board has a direct interest or responsibility?
> - Is the committee focusing on matters that cut into management's territory? (If so, perhaps an alternative is to have the committee operate as a management committee (possibly with some involvement from Board members?)
> - Is the committee operating in a way that supports and facilitates the deliberations of the Board or is it de facto supplanting the role of the Board?"[52]

Pointer and Orlikoff note that

> "a key concept of the Board-committee relationship is that committees should support and advance the work of the Board, and the Board should control and co-ordinate its committees. In many organizations, the reverse is unfortunately true. If a Board does not control its committees, it will be controlled by them. With various committees pulling in different directions, attempting to advance different agendas, and focusing on wildly different levels of detail, it is almost impossible for a Board to govern effectively and efficiently."[53]

In order to ensure Board ownership of the work that is done on its behalf by Standing Committees, it is essential that the Board undertake the following steps:

- establish a small number of Standing Committees that are clearly tied to the Board's core responsibilities;
- establish clear Standing Committees terms of reference and membership for review and approval annually;
- require the Standing Committee to establish an annual work plan and deliverables for approval of the Board;
- monitor the progress of the work of the Standing Committees at defined intervals within the Board's own work plan.

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[52] *Supra* note 33 at 27-8.

[53] *Supra* note 23 at 135.

The OHA/OMA Prototype By-laws recommend that the Board establish ten standing committees: Executive, Audit, Finance, Fiscal Advisory, Governance, Joint Conference, Medical Advisory, Nominating, Quality Assurance, Strategic Planning.[54] We would suggest that this is too many, particularly if considered in the context of reducing the size of the Board, where the distribution of committee workload among Directors will be come an issue.

Best practices in governance literature would suggest a smaller number of Board Standing Committees which are closely aligned with the key dimensions of Board responsibilities. Pointer and Orlikoff recommend a

> "zero-based committee structure" [which] forces a board to seriously re-evaluate its committee structure and functioning at the end of each fiscal year by dissolving its committees, determining which, if any, should continue and what additional committees are required to fulfill annual Board goals and objectives."[55]

We are not aware that this practice has been applied to any great extent among Ontario hospitals. However, we are aware that a number of hospitals are concerned that they have too many Standing Committees of questionable value or which are more related to management than governance and are therefore reviewing the effectiveness of their Standing Committee structures.

Whether or not a "zero-based approach" is used, there will inevitably be a core of Standing Committees that are required to support the Board in fulfilling its responsibilities. As in the case of Board roles and responsibilities, there is no single "right" way to structure these committees. However, best practices in the literature[56] and in Ontario hospitals would suggest that at a minimum, Board Standing Committees are required to support the Board in fulfilling the following responsibilities: finance, quality, executive management performance and the Board's own effectiveness.

The scope of responsibilities of these committee should include:

(i) Finance – A Standing Committee is required to recommend financial objectives and policies to the Board, ensure the preparation of the annual budget and operating plan for approval of the Board, monitor financial performance against indicators established by the Board and recommend corrective action as required in relation to financial performance.

Until recently, most hospitals have dealt with their Audit responsibilities through their Finance Committee. Consistent with recent experience in the corporate sector[57], best practices would also suggest a separation between the Finance and Audit function of the Board Standing Committee. The optimal approach is to establish a separate Audit Committee of independent Directors or to establish a distinct Audit Sub-Committee of the Finance Committee made up of independent Directors, which can operate directly with the external auditors in the absence of the CEO, CFO

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[54] *Supra* note 34, s. 5.1.1.

[55] *Supra* note 23 at 138.

[56] *Supra* note 23 at 139-41.

[57] *Supra* note 29.

and other management. The best practice would be to have an Audit Committee with a "minimum of three members, each member must be financially literate and independent".[58]

While the *Public Hospitals Act* requires the establishment of a Fiscal Advisory Committee, it is not a Board Standing Committee, but rather a Management Committee which advises the Board with respect to the operation, use and staffing of the hospital[59] through the CEO.

(ii) Quality – In addition to the Medical Advisory Committee (MAC), which is required under the *Public Hospitals Act*, a Standing Committee is required to recommend policies to the Board related to quality; recommend quality indicators to the Board and monitor performance against these indicators through reports from Management and the MAC on the processes of care, risk management and overall quality of organizational performance. The MAC advises the Board on the quality of medical/clinical care and the credentialing of professional staff arising from the medical/professional human resources plan.

In order to keep the number of Board Committees to a minimum, recently, several hospitals in Ontario have replaced the traditional Finance and Quality Committees with a "Performance Monitoring" Committee,[60] which takes a more integrated approach to the oversight of financial performance, quality of patient care and overall organizational performance. It will be important to evaluate the merits of this approach as an alternative to the traditional Finance and Quality committees, once these hospitals have a few cycles of experience with this committee.

(iii) Executive Management Performance – The key functions which must be fulfilled are the establishment of annual performance goals and performance indicators with the CEO and Chief of Staff/Chair of the MAC for approval of the Board, annual evaluation of the performance of the CEO and Chief of Staff/Chair of the MAC and recommendations to the Board with respect to compensation and succession planning for these two positions. Experience has shown that Standing Committee support to the Board regarding Executive Management performance could be approached in at least two different ways. Best practices include assignment of these functions to the Executive Committee or, alternatively, establishing a dedicated Standing Committee for this purpose where the Board has determined not to establish an Executive Committee.[61]

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[58] Ontario Securities Commission, *Notice of Multilateral Instrument 52-110, Audit Committees.*

[59] *Supra* note, s. 5.

[60] Toronto East General, Hamilton Health Sciences, Sudbury Regional Hospital.

[61] For example, Toronto East General Hospital and Sudbury Regional Hospital have assigned these functions to the Executive Committee whereas Halton Healthcare Services has established a CEO and Chief of Staff Recruitment and Retention Committee in absence of an Executive Committee.

(iv) Board's own effectiveness – the key functions which must be fulfilled are development and periodic review of governance policies; structures and processes for recommendation to the Board; establishing processes for Board and individual Director evaluation; establishing processes and programs for initial orientation of new Directors and ongoing Board education; succession planning for Directors and Officers, including developing maintaining the Board profile of current and required skills and expertise; establishing and implementing an annual process for the recruitment of new Directors as required. Given the scope of these responsibilities, there is growing acceptance in Ontario of the need for a Governance Committee to oversee these responsibilities including the traditional functions of a Nominating Committee. Some Boards, however, choose to establish a separate Nominating Committee or a Nominating Sub-Committee of the Governance Committee. In either case, the Governance Committee is responsible for recommending to the Board the policies and processes to guide the work of the Nominating Committee.

(v) Other Potential Committees

Strategic Planning

With respect to the Board's responsibility for **"ends"** (strategic direction) there is no consistent or "right" practice in that some Boards wish to establish a Committee to support the Board in this responsibility, while others wish to retain this as a responsibility of the Board as a whole through periodic Board strategy sessions. A middle ground is to periodically establish an Ad Hoc Strategic Planning Steering Committee comprised of members of the Board, management and a cross-section of internal and external stakeholders.

Regardless of the specific approach which is used, it is essential that the Board engage in a strategic planning process at regular intervals (3-5 years) at which time it reviews its vision, mission and values, conducts and environmental scan, identifies strategic issues and either re-affirms current strategic directions or establishes new strategic directions. This process is essential not only to enable the Board to anticipate and respond to changing circumstances but also to renew its relationships with internal and external stakeholders.

Community Relations

In the context of the Board responsibility for "Building Partnerships" with its communities, some Boards have established Community Relations Committees. There is some disagreement as to "best practices" with regard to the structure and role of a Board Community Relations Committee. The typical rationale for such a committee is to support the Board in ensuring that the hospital is responsive to and functioning in a manner that best serves the needs of the community.

There are two basic approaches. In one, the Community Relations Committee directly hears from the community and translates community concern to the Board and to Management. Because the emphasis for translating special interests is placed on the Community Relations Committee, it enhances the possibility it will become a lightning rod for political complaints, many of which will specifically relate to operational issues. The alternative approach is that, in lieu of a standing committee, the Board establishes the policy framework within which the

Management team is expected to actively engage with special interest groups and be responsive to the needs of the community so that solutions can be found at the operations level. Success at the operations level should effectively solve the problems. This leaves the Board with the principal responsibility of monitoring the performance of the hospital management in responding appropriately to the identified special needs of the community.

Both the Wellesley Central Hospital and the Sudbury Regional Hospital put an emphasis on Management to address special interests in community relations.[62]/[63] We believe this second approach is the best practice as it links community needs to the operational and programmatic responsibilities of management.

Executive Committee

Historically, in many hospitals there has been a tension between the respective roles of the Board and Executive Committee arising from the Executive Committee assuming decision-making responsibilities for matters, which rightly belong to the Board. In some organizations, this has resulted in a decision to eliminate the Executive Committee.

The 1994 TSE Report noted that

> "Boards of Directors have become much less reliant upon Executive Committees… "The historical model of the Executive Committee comprised of the real decision-makers within the Board has virtually disappeared. We support this trend. Executive Committees tend to create two classes of directors, those on the inside and those on the outside, with the result that those directors on the outside may lose interest and feel little sense of accountability for corporate decisions."[64]

In order to facilitate the Board's ownership of its business and full participation by all Board members, increasingly, the practice in Ontario hospitals is to limit the role of the Executive Committee to exercise such powers as may from time to time be given to it by resolution of the Board, including to make decisions in matters of administrative urgency.

Often, the specific responsibilities assigned to the Executive Committee relate to Executive Management performance as outlined above. Some Boards also assign to the Executive Committee the responsibility for the co-ordination of the annual Board work plan and Board meeting agendas. The caution here is to ensure that the Executive Committee in determining the Board agenda does not pre-conduct the substantive discussion which should be the prerogative of the Board at the Board meeting.

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[62] Sudbury Regional Hospital, *Board Policies Part v-a – Build Relationships.*

[63] Scott Rowand "*Responsive Governance: The Wellesley Experience"*, [unpublished].

[64] *Supra* note 21 at 43.

b. Ad Hoc Committees

From time to time, the Board may wish to establish time-limited Committees to consider and make recommendations on specific matters which are a priority for the Board at a particular point in time. For example, an ad hoc Capital Project Committee may be required to oversee construction on a time-limited basis. Such committees also afford the opportunity to retain specific additional expertise from within the community.

c. Non-Directors on Board Standing and Ad Hoc Committees

There is not a consistent or a "right" approach among Ontario hospitals in the appointment of additional non-Directors as members of Board Standing Committees. Some Boards see the appointment of non-Directors to Standing and Ad Hoc Committees as an opportunity to extend the reach of the hospital Board into the community and identify potential recruits for subsequent nomination to the Board. The appointment of non-Directors from within the membership of the Corporation also provides the opportunity to utilize the corporate membership as a pool for recruitment.

The key issues for consideration in the appointment of non-Directors to Board Standing and Ad Hoc Committees include:

- the need for an explicit Board policy which sets out the rationale for the appointment of non-Directors, the specific Committees to which they will be assigned and expectations as to their role and responsibilities;

- a balance between Directors and non-Directors with a majority of Directors on the Committee to ensure ownership of the Committee's work by the Board;

- a systematic transparent process for the nomination of non-Directors and approval by the Board of Directors.

9. Corporate Membership

Corporate membership provides the root of corporate governance. The members of the Corporation elect the Board, approve the by-laws, appoint the auditor and approve the financial statements of the Corporation. The members also provide the potential to be the basic source for the identification of future Directors of the Board and for volunteers for Board committees and other hospital activities. In some hospitals, the members also are seen as an important source of input to the Board and organization on program and service effectiveness, priorities and community health needs. Many hospitals are starting to ask how they can more meaningfully engage corporate members for the benefit of the hospital. Unfortunately, there is little in the governance literature on the role and relevance of the corporate members to effective hospital governance.

The 1990 OHA/OMA Prototype Hospital By-Laws and the 2003 edition[65] establish five categories of membership:

- Life membership;
- Long-term membership;
- Annual membership (corporate);
- Annual membership (individual); and
- Honorary.

Both sets of by-laws are generally similar and reflect a more traditional membership structure that was designed to maximize the number and tenure of the membership at a point of time when the membership was the primary source of fundraising in the community.

At the other extreme, some Boards have historically restricted their corporate membership to the members of the Board and, in some cases, expanded it to include retired members of the Board. While this approach has provided stability in the Board and the membership, it has increasingly been the subject of criticism in that these self-perpetuating Boards were not reflective of or connected with the community.

Into the 21st Century, the report of the Steering Committee, *Public Hospitals Act* Review contained a number of recommendations emphasizing a greater community orientation. The Health Services Restructuring Commission (HSRC) stipulated that hospital Boards not only become more representative of the communities served, but encouraged the Boards to be more open and accessible in their work. Consequently, hospitals have been opening their membership to the wider community to address community accountability.

The amalgamated hospital corporations – both voluntary and directed by the HSRC– reformed their membership structures and generally opened up membership as an opportunity to build awareness and support for the new organization both within the legacy organizations and the broader community. The common Board membership choices examined by the Steering Committees during the amalgamations processes in the period 1995-2001 were:

(1) The Board Membership Model

The Board of Directors reserves to itself the membership by designating the Board members as the sole members of the Corporation.

(2) Open Membership Model

In these cases anyone on payment of an annual fee can become a member.

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[65] *Supra* note 34, s. 2.1.2.

(3) Membership by Application

The Corporation establishes an application form that must be completed and submitted by anyone wishing to become a member. The Board of Directors must approve the application before the applicant becomes a member.

(4) Electoral College/Closed Constituency Membership

The Board of Directors approves different groupings of stakeholders and invites them to elect a certain number of members out of a designated total number of members for the Corporation. These members, once elected, become the membership of Corporation for a fixed term.

The Board Membership Model was generally rejected because the HSRC and the government were openly encouraging a more open membership reflective of the community.

The Open Membership Model and Membership by Application were, with some modifications, typically selected as the models of choice. The most popular was Membership by Application combined with a cut off date two or three months before the annual meeting. The attractiveness of this model was that the criteria for membership would include support for the objectives and best interests of the hospital and the application would be subject to Board approval, thus discouraging special interests from hijacking the Board and also would create a potential pool of future candidates for the Board.

The so-called Electoral College Model/Constituency Membership was developed at the Wellesley Hospital and was subsequently customized for use at the Centre for Addiction and Mental Health. While this model is more complex and cumbersome to administer than the Open Membership Model, it has substantial attraction, particularly for hospitals that have a defined range of constituencies and who, as part of their organizational culture, have a significant commitment to community involvement and are looking to these constituencies to provide substantive input to shape the direction of the organization over time.

Recently, Lakeridge Health reviewed its membership structure to determine whether an alternative model to open membership would more effectively advance the relationship between the organization and its communities. Having evaluated each of the models identified above as well as the model of the Community Advisory Council, which is used in several Regional Health Authorities, the Board concluded that they would maintain the open membership. In addition, the Board agreed to establish as a priority new mechanisms for fulfilling the functions of community engagement as distinct from the functions of corporate membership.

The Electoral College Model at Wellesley enhanced the profile of the community in the eyes of hospital management and resulted in a management team that was far more responsive to the special needs of the community than would otherwise have been the case.

The Centre for Addiction and Mental Health (CAMH) has a " Closed Constituency Membership" or " Electoral College" model. The Membership of CAMH consists of 70 members drawn from 12 different constituencies including consumers of mental health and addiction services, family

members, public health agencies, CAMH employees, community mental health and addiction agencies, etc. CAMH draws on its membership, not only to fulfill the legal requirements of the membership under the *Corporations Act*, but also as a key vehicle for dialogue on the programs, policies and future directions of the organization. CAMH believes that in order to meet their legal responsibilities, the members must be informed and have an opportunity to engage actively with the Centre throughout the year. This is achieved in the following ways:

- Regular Meetings and Information - The Members are invited to two all-day meetings per year. The purpose of these meetings is to update the Members on the activities of CAMH, to provide an opportunity to obtain the perspectives of the Members on a variety of issues, and to enable the Members to network and to increase their own understanding of mental health and addiction issues. In addition, the Members receive regular mailings from CAMH as well as on-going communication on important issues.

- Participation in CAMH Activities - Members are informed of opportunities to serve on the CAMH Board, committees, task forces, advisory groups, etc. While under no obligation to participate in this manner, many Members who are interested in particular aspects of CAMH's work want to contribute their time and experience. Major CAMH initiatives, such as the renewal of its strategic plan, include consultation with the Members.

This model may be of interest to those Boards which are endeavouring to engage with their corporate members beyond the annual meeting.

As discussed in Chapter 5, Boards must be accountable in their governance activities to their communities, as well as to the government for the service they provide to their catchment area. For Boards to be responsive to their communities, they should be sensitive to and reflective of their communities and this is more likely to occur when the membership of the Corporation that elects them is, in turn, committed to the role of the hospital and genuinely reflective of the communities served. Whichever model is selected, the key considerations to ensure alignment of the corporate membership with the effective functioning of the Board are:

- a determination by the Board of the preferred roles and responsibilities of the membership as a matter of Board policy, ranging minimally from fulfilling the legal requirements of the annual meeting under the *Corporations Act*, to serving as an ongoing resource to provide advice to the organization and linkages between the organization and its community;

- arising from the membership roles and responsibilities, identification of explicit criteria for the selection of corporate membership that would preclude the potential for inappropriate members or worse, a hijacking, and include such matters as commitment to the Vision, Mission and Core Values and work of the hospital; willingness to devote time and energy to assist the hospital; representation within the membership of the key constituencies or communities to be served by the hospital;

- a systematic application process for membership and a process for annual approval of the membership by the Board of Directors;

- a mechanism for maintaining ongoing communication with the membership to ensure their ability to meet the expectations which have been established by the Board.

CHAPTER 4: Critical Elements of Effective Governance: Process

Effective governance also requires that Boards establish clear policies and processes to support the effective functioning of the Board and its relationship with management. The following matters have been identified in governance reviews of Ontario hospitals as some of the governance process issues which require particular strengthening:

- Development of comprehensive Board policies related to each area of the Board's responsibilities;
- Development of annual Board goals and work plan;
- Development of agendas and supporting documentation for Board and Standing Committee meetings, which are also aligned with the Board's roles and responsibilities;
- Appropriate discussion at open Board meetings and use of in-camera sessions;
- Well-understood roles and responsibilities of Board Officers and Committee Chairs;
- A nominations process for the selection of Directors which is systematic, clear and transparent;
- An effective orientation program for new Directors and continuing education program for the Board as a whole;
- Processes for the annual evaluation of the performance of individual Directors and the Board as a whole;
- Process to establish the accountabilities and performance goals of the CEO and Chief of Staff/Chair of the MAC as a foundation for annual performance evaluation;
- Processes for physician credentialling and appointment;
- Clear processes for budget and program approvals;
- Establishment of performance indicators to facilitate effective oversight and monitoring of hospital operations;
- Processes for strengthening linkages with other provider organizations.

1. Board Policies

Consistent with the Board's essential role of formulating policies to provide guidance to those empowered with the responsibility to manage hospital operations, it is important that the Board have a systematic approach to the codification of Board policies in a formal Board Policy Manual and review of these policies on a regular basis.

The need for systematic development of Board policies was initially introduced by John Carver in the context of policy governance.[66] Hospitals which have employed the Carver model of Policy Governance, typically establish Board policies in the following categories: organizational aims (ends); governance approach; management limitations, Board/CEO relationship.

Recently, as part of its governance renewal process utilizing the Pointer, Orlikoff framework[67], the Sudbury Regional Hospital established a comprehensive set of Board policies[68] which are specifically linked to each of the six areas of responsibility of the Board: Ends, Executive management performance, Quality, Finance, the Board's own effectiveness and Building Partnerships. These Board policies, which are codified in a Board Policy Manual, ground all of the work of the Board in that they are specifically referenced in relation to every Board agenda item. This not only provides context for the Board's deliberations, but also reinforces the importance of policy among the Board's roles. This is consistent with Pointer and Orlikoff's contention that

> " The single most important Board role is policy formulation; it is the primary mechanism boards have to influence their organizations and it provides the best tangible evidence that responsibilities are being fulfilled on behalf of stakeholders. Additionally, execution of the decision and oversight roles depends on a comprehensive set of well-formulated policies. To truly make a difference, the centre of governance work must be policy formulation."[69]

2. Annual Board Goals and Work Plan

The development of annual Board goals is an important exercise to focus the work of the Board, clearly articulate the Board's expectations of its own contribution to ensuring the success of the organization and to establish the benchmarks against which the Board can evaluate its performance at the end of the year.

Board goals must be translated into the annual Board work plan to ensure that they are actually implemented through the work of the Board and its committees. In addition, the Board work plan can be constructed from the schedule of matters to be considered by the Board as specified in the Board policies.

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[66] *Supra* note 22.

[67] *Supra* note 23.

[68] Sudbury Regional Hospital, *Board Policy Manual*, (July 2003).

[69] *Supra* note 23 at 82.

The Board work plan is an extremely useful tool to enable the Board to anticipate the matters which it will consider in the course of the year and to track the status of these matters at the Board and Standing or Ad Hoc Committees. In addition, the Board work plan used in combination with the Board goals provides the key benchmark for annually evaluating the performance of the Board in relation to its roles and responsibilities.

3. Board Agendas and Reporting Formats

The structure and content of Board meeting agendas are critical to the effective functioning of the Board. Critical elements which are required to maximize the effectiveness and efficiency of a Board meeting include:

- agendas driven by and aligned with the annual Board goals and work plan;
- agendas which specify the role of the Board with respect to the matters to be considered (i.e., policy formulation, decision-making, oversight);
- specific reference to the relevant Board policy as a context for consideration of the matter;
- separation between matters which require Board action and information items;
- assignment of specific time allocation for agenda items;
- decision-support documents which are succinct, focused and provide a clear statement of the options which were considered as a foundation for the recommendations, which the Board is being asked to approve[70];
- brief summary reports instead of minutes from Board Standing and Ad Hoc Committees, which highlight matters discussed, action agreed upon and recommendations for consideration by the Board;
- evaluation at the end of the meeting.

4. Open and In-Camera Board Meetings

Another matter which significantly affects the effective functioning of Board meetings is the balance between open and in-camera meetings. In 1998**,** in the interest of enhancing transparency and links with internal and external stakeholders, OHA established a policy of open hospital Board meetings. This policy is now reflected in the OHA/OMA Prototype By-laws which include a prototype Board policy for open and closed sessions of meetings of the Board.[71] Essentially, the Board is expected to convene in open session to deal with all matters with the

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[70] The Hotel Dieu Hospital in Windsor has developed a decision-support format, which has been also utilized by the Sudbury Regional Hospital.

[71] *Supra* note 34, Appendix B - Part 1.

exception of personnel, property, negotiations, contractual matters and legal matters. Similar provisions have been included in many hospital by-laws.

Most hospitals now hold open Board meetings that allow for community and media attendance. The common rationale is that open meetings are deemed to be positive because they promote and portray Board openness and accountability. However, experience in the implementation of open Board meetings over the past decade has raised a number of concerns:

- open meetings contribute to and reinforce the misconception that the hospital Board is accountable only to the community and undermine the Board's focus on its fiduciary obligations and accountability to the MOHLTC;

- there is a tendency to include in the in-camera agenda matters which may not strictly comply with the by-law provisions for in-camera meetings but which may be sensitive to the community and therefore are seen to require confidential and open discussion, which would not be possible in an open meeting;

- where sensitive matters are included in the open agenda, there is often a reluctance to engage in full discussion in the presence of the media;

- experience has shown limited attendance at open Board meetings by internal or external stakeholders which therefore renders the open meeting of limited value as a mechanism for linking with the community.

In the context of changing understanding of Board accountabilities, it may be timely for the OHA and the MOHLTC to revisit the practice of open Board meetings. In the event that open Board meetings were to be discontinued, it is still essential to ensure alternative mechanisms for communicating the work of the Board to the community and establishing mechanisms to understand the needs and expectations of the community. These might include:

- media briefings by the Board Chair and CEO immediately following Board meetings;

- communiqués issued both internally and externally which summarize and highlight the proceedings of the Board meetings;

- periodic community meetings held specifically to engage in dialogue with the community to obtain their perspectives on the work of the hospital and key issues for consideration by the Board and Management;

- program advisory committees to Management.

Also, a joint communications strategy between the OHA and MOHLTC would be essential to support local hospitals as they change their practices and by-laws in this regard in the event of negative reactions from the community and media.

5. Roles and Responsibilities of Board Officers and Committee Chairs

The OHA/OMA Prototype By-laws set out the duties of the Board Chair, Vice-Chair, Treasurer and Secretary.[72] They do not, however, address the duties of the Committee Chair. In addition to these by-law provisions, the literature and recent experience in some Ontario hospitals would recommend the establishment of additional Board policies which elaborate on the role and qualifications of the officers and Committee Chairs. Specifically, it is important to make explicit the type of leadership which these positions are expected to demonstrate within the Board and on behalf of the Board within the organization and external community. It is also important to make explicit the key qualifications for these positions in terms of experience within the Board, personal attributes and specific skills and expertise. Finally, it is essential to clearly define the term of office and the process for nomination and election of the Officers and Committee Chairs.

6. Nominations Process for the Selection of Directors

Effective recruitment and selection of Directors necessitates a nominations process, which is systematic, clear and transparent. The essential framework is provided by the Guidelines for the Selection of Directors and Board profile described in Chapter 3, Section 4 above. The responsibility for the implementation of the nominations process on behalf of the Board rests with the Governance Committee or Nominating Sub-Committee of the Governance Committee as described in Chapter 3, Section 4 above.

Critical steps to achieve a systematic, clear and transparent nominations process include:

- developing the Board profile of current Board members to identify current skills and expertise, gaps and succession planning needs over 2-3 years;
- canvassing Board members annually for their intentions with respect to re-election and aspirations with respect to committee assignments and succession to leadership roles within the Board;
- conducting a search for prospective candidates to fill the identified gaps through a series of mechanisms, including internal canvass of Board members, advertising in the community and possibly use of an executive search firm;
- providing a package of information on the web site or alternative medium to enable prospective candidates to develop a clear understanding of the organization and expectations of Directors;
- requiring prospective candidates to complete an application which specifies their reason for seeking a position on the Board and their relevant skills and experience;
- evaluating prospective candidates against the guidelines for selection of Directors;
- interviewing a short list of candidates;
- recommending a list of nominees to the Board for approval and recommendation to the annual Meeting of the Board.

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[72] *Supra* note 34, s. 4.3.

Many hospital by-laws permit the members of the Corporation to make nominations from the floor of the annual meeting. This process could create problems for the Nominations Committee in providing a slate consistent with the Guidelines for the Selection of Directors and upset the transparent and fair process for candidate selection. The best practice consistent with the Guidelines for the Selection of Directors should be for the members to be provided with ample notice to recommend candidates to the Nominations Committee as part of the selection process in developing the slate.

7. Orientation for New Directors and Continuing Education for the Board as a Whole

Effective participation of individual Directors in the work of the Board is significantly influenced by their level of knowledge of the organization, the Board and the environment within which the hospital operates. Responsibility for the ensuring the acquisition of this knowledge must be assumed by the Board on behalf of all of its members and by the individual Director. As in the case of the process for nomination of Directors, the process for education must be systematic, comprehensive, clear and transparent.

At the present time, there is not a consistent approach or content of the orientation of new Directors or continuing education of Boards among Ontario hospitals. In the case of orientation of new Directors, experience ranges from the CEO providing informal sessions for new Directors one-on-one, to the Governance Committee organizing a comprehensive program for all new Directors provided by the Board Chair, Governance Committee and Management team. In the case of continuing Board education, experience ranges from hospitals expecting Directors to pursue educational opportunities through programs offered by the OHA to Governance Committees organizing an annual program of Board education to be provided at the beginning of each Board meeting.

Best practices would suggest the importance of mandatory comprehensive, in-depth orientation programs for new Directors immediately upon election or appointment to a hospital Board. The scope should include an orientation to the Board, to the hospital and to the broader health system in which the hospital operates including the role of the Ministry of Health and Long-Term Care and related providers. The orientation should be supported by a written manual including hospital legislation, the hospital by-laws, Board policies, organization chart, financial and operating statistics, the current strategic and operating plan and Board/Committee meeting schedules. Best practices also would suggest that all Directors participate in a refresher orientation program at least once during their term on the Board, ideally at the time of beginning a second or third term.

With respect to continuing education of Directors, best practices would suggest a combination of on-site education sessions scheduled as part of regular Board meetings and the opportunity for Directors to attend external educational sessions provided by the OHA and other related organizations.

A program of on-site sessions should, ideally, be developed by the Governance Committee and CEO. They should include specific aspects of the hospital's mandate and programs, broader health policy and system issues that can be expected to impact on the hospital and governance policy matters that can facilitate the effective functioning of the Board. In addition, an annual Board retreat should be seen as an integral component of Board education.

As part of its new strategic directions, the OHA has committed to renew the Trustee Institute.

8. Evaluation of the Performance of the Board and Individual Directors

There is not a consistent approach to the scope, frequency or implementation of Board and Director evaluation or corrective action arising from evaluation among Ontario hospitals. Some Boards remain opposed to individual Director evaluation on the basis that it is not appropriate to subject volunteers to either self-assessment or peer review. Bill Dimma recently noted that:

> "Individual Director assessment is never easy. It is potentially both unsettling and divisive. And yet it is necessary. The principle of accountability is universal."[73]

While many Boards have established a policy commitment to annual Board self-evaluation, other priorities and pressures often relegate this to a low priority which is implemented, at best, sporadically. The Toronto Stock Exchange has concluded that

> "Regular assessment of the Board's effectiveness, and the contribution of individual Directors is essential to improve governance practices. The governance system should include a process for the evaluation of the work of the Board, its committees, and individual Directors. The focus of such assessments should be on how performance can be made more meaningful in setting and achieving goals that add value. The results of such evaluation should be internal to the Board but disclosure should be made that such evaluations are indeed carried out." [74]

The tools for evaluation should be clearly aligned with the Roles and Responsibilities of the Board and individual Directors. Several Ontario hospitals have established evaluation tools which can be utilized as precedents by other hospitals.[75]

The responsibility for the development of the evaluation process and tool and for the implementation of the process, should ideally be assigned by the Board to the Governance Committee. The timing of the process should be linked to the annual Board cycle so as to inform the implementation of corrective action as required and the process for recruitment of individual Directors.

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[73] William A. Dimma, *Excellence in the Boardroom: Best Practices in Corporate Directorship*, (Canada: John Wiley & Sons Inc., 2002) at 19.

[74] *Supra* note 29 at 18.

[75] For example, Sudbury Regional Hospitals, Hamilton Health Sciences, Toronto East General and Halton Health Care Services have recently developed Board and individual Director evaluation tools.

9. Process to Establish the Accountabilities and Performance Goals of the CEO and Chief of Staff/Chair of the MAC

The establishment of clear annual performance goals for the CEO and Chief of Staff/Chair of the MAC is an essential prerequisite to the Board's oversight role in relation to its responsibility for Executive Management Performance. The performance goals should be developed jointly by the incumbents and the Board Committee which has been designated the responsibility to support the Board in this area of its responsibility, and then presented to the Board for approval. In the case of the CEO, the timing of this process should coincide with the approval of the annual operating plan to ensure alignment between the goals and objectives of the operating plan and the accountability of the CEO for its implementation. In the case of the Chief of Staff/Chair of the MAC, the timing should be aligned with the beginning of the annual MAC cycle.

The performance goals for the CEO should be clearly aligned with the hospital's strategic and operating plan and include specific, actionable and measurable financial and clinical targets. The performance goals of the Chief of Staff/Chair of the MAC should be consistent with his/her responsibilities regarding quality and clinical human resources planning.

The performance goals of the CEO and Chief of Staff/Chair of the MAC provide the baseline against which their performance is evaluated annually and compensation is determined. Again, the process for implementation of these components of the Board's responsibility for Executive Management performance can be assigned by the Board to a Standing Committee. However, it is essential that the full Board has input into the evaluation and receives a report and recommendations arising from the evaluation related to both performance and compensation.

10. Processes for Physician Credentialling and Appointment

As hospital Boards experience increasing pressures on resource allocation, one of the key issues in many, if not most, hospitals is the influence and behaviour of physicians. While oversight of physician credentialling and performance is one of the Board's primary responsibilities under the *Public Hospitals Act*, it receives, at best, superficial attention in many hospital Boards. Many Boards restrict their role to the approval of medical staff appointments on the recommendation of the MAC. This is usually a rather perfunctory process in which the Board adds little value, as the Board must rely on the judgement of the MAC as to the specific competencies of individual physicians. However, a more important element of the credentialing process, which is often overlooked, is Board oversight of the appointment and re-appointment criteria and process. It is important for the Board to ensure that the criteria and process of medical staff appointments are aligned with the hospital's physician human resource plan, the operating plan and the strategic direction of the hospital. This is essential not only in relation to the quality of patient care, but to also mitigate some of the issues around physician impact on hospital spending.

11. Processes for Budget and Program Approvals

Hospital Boards across Ontario have been increasingly challenged in recent years with the competing expectations of introducing new programs, services and volumes to meet the needs of their community, while at the same time living within their resources in order to avoid financial shortfall. Numerous operational reviews have identified the significant risk incurred by hospitals which have initiated new or enhanced programs with the expectation that unfunded expenditures would ultimately be covered by the MOHLTC.

This issue will be addressed much more extensively in Chapter 5, Section 4 on Hospital Accountability. However, from the perspective of governance processes, Mark Hundert noted in a recent article that

> "For the Board of a hospital to exercise its responsibility in ensuring effective management and the financial health of the hospital, there must be strong processes for operational planning and budgeting and for reporting on progress in achieving these plans and budgets."

He systematically identifies the initiative and steps which hospital Boards must take in setting operational objectives, performance and [financial] targets, critically reviewing and approving the operating plan and budget and requiring management to report on variances against the budget and targets

> "to enable Board members to better exercise their responsibility for monitoring and maintaining the financial health of the hospital"[76].

In discussing the enhancements which are required to improve the effectiveness of financial reporting to the Board, he recommends that

> " the reports should include a set of corporate performance (productivity) indicators that present a comparison of the Corporation to its own plans and to benchmark levels of performance of other hospitals."[77]

12. Establishment of Performance Indicators to Facilitate Effective Oversight and Monitoring of Hospital Operations

Consistent with the Board's role in oversight or monitoring of organizational performance, a current challenge facing hospital Boards across Ontario is the development of appropriate performance indicators to support the Board in fulfilling this role. A detailed discussion of the process required to establish Board level performance indicators is beyond the scope of this paper. However, the essential considerations in the context of governance best practices are the importance of:

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[76] Mark Hundert, "Issues in the Governance of Canadian Hospitals III: Financial Oversight" (2003) Spring Hospital Quarterly at 64-66; See also Mark Hundert & Adam Topp, "Issues in the Governance of Canadian Hospitals IV: Quality of Hospital Care" (2003) 6(4) Hospital Quarterly.

[77] *Ibid*. "Issues in the Governance of Canadian Hospitals III: Financial Oversight" at 66.

- establishing performance indicators in relation to each of the dimensions of the Board's responsibilities, i.e., ends, executive management performance, quality, finance, the Board's own effectiveness

- establishing Board policies on the approach to performance monitoring within the Board and its standing committees;

- establishing, in co-operation with management, a small number of indicators that are measurable and relevant to the Board's governance responsibilities as distinct from management's operational responsibilities;

- establishing a process whereby the appropriate Board Standing Committee monitors performance against the agreed upon indicators at specified intervals during the course of the year and reports to the Board on both its findings and recommendations respecting any corrective action which may be required.

13. Processes for Strengthening Linkages with Other Provider Organizations

Over the past decade, as a result of hospital restructuring, resource constraints within the hospital and broader health sector and increasing expectations for improved integration of health services delivery, hospital Boards are being increasingly challenged to look outside their walls. It is now widely accepted that hospital Boards must develop both an understanding of and strong linkages with other providers within their communities and regions. To this end, several Boards are explicitly defining " Building Relationships" as one of their responsibilities as identified earlier. However, there are not necessarily well-established mechanisms to achieve this and to date there is limited provincial policy direction or guidance. Consequently, Boards have initiated a variety of local processes in different parts of the province including:

- regional networks of Board Chairs and CEOs of health services organizations which meet periodically to identify opportunities for improved communication and integration of services[78];

- periodic forums for dialogue with Board counterparts of other provider organizations as part of hospital Board meetings or Board retreats;

Recently the MOHLTC has signalled new policy directions related to the integration of clinical and support services among hospitals and between hospitals and other community providers and potential performance/accountability agreements with multiple providers. This will significantly impact the need for hospital Boards to commit a portion of their governance time to participate in joint governance processes with their counterparts in other organizations. Furthermore, these processes will of necessity extend beyond the information sharing of the past to joint policy formulation, decision-making and oversight in relation to new collaborative efforts and joint ventures.

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[78] Examples include the Health Care Network of Southeastern Ontario, Integrated Strategic Alliances and Networks in Southwestern Ontario, 19 Rural and Northern Health Networks.

There are a variety of potential structural mechanisms for partnering[79] that Boards and the MOHLTC will need to consider in order to meet MOHLTC and community expectations for greater integration and consolidation of programs and services in the future. These include:

- Advisory Model
- The Contractual Model
- The Partnership Model
- A Joint Governance Model
- A Shared Services Corporation Model.

The specific considerations in relation to each of these mechanisms is beyond the scope of this paper. However, the key point is that in future, processes will be required among hospitals and between hospitals and other community providers to establish these new governance mechanisms.

[79] McMillan Binch, *Comparison of Partnering Arrangements*, (June 2003) [unpublished].

CHAPTER 5: Accountability

1. Context and Drivers

Much of the success of Ontario's health care system relies on an effective understanding between the MOHLTC as the government's agent charged with responsibility for developing and overseeing a sustainable health care system in accordance with the principles of the *Canada Health Act* and the hospitals of Ontario that are independently governed. For too long this relationship has been undefined, which has resulted in a system that is unnecessarily combative and inefficient. The relationship must be renewed and redefined so that the responsibilities of each are clearly established resulting in an environment that will more efficiently and effectively serve the public while enhancing patient care. This renewal and redefinition will be a major undertaking that will require many years to perfect – but it must begin now and both the MOHLTC and the hospitals must be committed to it.

There are three primary drivers behind the current demands for accountability:

- fiscal restraints which are increasing tensions between central governments and local bodies (RHAs/hospitals/other health organizations);
- growing interest in quality improvement/quality assurance and audit in Europe, Australia, the US and Canada;
- increasing availability and growing use of performance measurement.[80]

Specifically the 2003 First Ministers' Health Accord made accountability front and centre:

> "First Ministers commit to enhancing the transparency and accountability of our health care system while ensuring that health care remains affordable…. First Ministers agree to establish a Health Council to monitor and make annual public reports on the implementation of the Accord, particularly its accountability and transparency provisions. The Health Council will publicly report through Federal/Provincial/Territorial Ministers of Health and will include representatives of both orders of government, experts and the public. …"[81]

The Federal/Provincial/Territorial differences on fiscal accountability, scarce funding and the creation of the National Council on Health will further add to the pressure for good accountability systems. Given the hospital deficits, working capital shortfalls and infrastructure renewal demands, the assurance that every health dollar is carefully accounted for will be paramount.

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[80] Adalsteinn D. Brown, G. Ross Baker, Geoffrey M. Anderson, & Unnur K. Brown, "Accountability in Health Care: A Review of the Experience of Selected OECD Countries" (1999) University of Toronto.

[81] First Ministers, *2003 First Ministers' Accord on Health Care Renewal*, (5 February 2003).

While the focus of this paper is to recommend a new approach to governance and accountability for the hospitals, it is essential that it be understood that the implementation of an effective program of governance and accountability in the hospitals requires a clear undertaking from both the MOHLTC and the OHA that they will address their accountabilities to the hospital system. This process has started with the Joint Policy and Planning Committee initiative announced in December 2003.[82]

2. The Basics of Accountability

Accountability can only be effective if there is a clear and mutual understanding of its meaning to both parties to the accountability. Consequently the first question must be: What is Accountability?

The Treasury Board Secretariat of the Government of Canada defines Accountability as:

> "Accountability is a relationship based on the obligation to demonstrate and take responsibility for performance in light of agreed expectations." [83]

The Broadbent Report on Improving Governance and Accountability in Canada's Voluntary Sector stated:

> "Accountability is the requirement to explain and accept responsibility for carrying out an assigned mandate in light of agreed upon expectations. It is particularly important in situations that involve public trust. However, a commitment to accountability should be thought of not only as answering to external audiences, but also as a constructive tool for organizational development, enhancing management practices, self evaluation and strategic planning."[84]

Partners in Health: Forging An Accountability Framework, 2000 stated:

> "Accountability is the obligation to answer for results and the manner in which responsibilities are discharged. Accountability cannot be delegated. One is **responsible for** something, but **accountable to** some one… Put simply, accountability means being expected to answer for the results of your actions and decisions. To meet these expectations we must measure results in order to provide a basis for decision making that will drive change and improve performance." [85]

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[82] *Supra* note 17.

[83] Accountability Expectations and Approaches, online: Treasury Board Secretariat, Government of Canada <http://www.tbs-sct.gc.ca/rma/account/account_e.asp>.

[84] Canadian Centre for Philanthropy, *Building on Strength: Improving Governance and Accountability in Canada's Voluntary Sector*, (Toronto: Canadian Centre for Philanthropy, 1999) at 2.

[85] OHA/MOHLTC, *Partners in Health: Forging an Accountability Framework*, (2000).

Most importantly, in both the "Broadbent Report" and in "Partners in Health" the message is not only responsibility to answer for performance but the expectation that accountability be used as a tool for enhancing management practices and bringing about organizational change to improve performance.

Without the discipline of the above definitions, the use of the word "accountability" to date has been counterproductive. In the absence of an overarching accountability framework, there has been too much of a blame game and endless finger pointing.[86] This, in turn, has led to destructive debate between the MOHLTC and the hospitals with the former accused of under-funding and the latter accused of mismanagement. The commitment from both the MOHLTC and the hospitals to begin the process of adopting the disciplines of the theory and practice of accountability is essential, if those who rely on the health care system are to reap the benefits of accountability.

The words "partner" and "partnership" are often used to describe the relationship between the MOHLTC and the hospitals of Ontario. It is important that there be a clear understanding of these words in considering accountability. Hospitals and the MOHLTC are partners to the extent that they co-operate in a health venture and each has certain independence and implicit or formal obligations to each other. They share a broad common cause to serve the health care needs of the community but they are not part of a single business enterprise that proportionately shares risks, profits and losses. They are unequal in legislative power, as in the final analysis, the MOHLTC has the authority to take over the governance of hospitals. The accountability relationship is basically a contractual relationship with defined responsibilities. The word "partner" is primarily of value in describing the collegial relationship that both must share to ensure that the contract is successful.

3. Accountability Framework

On December 15 and 16, 2003 the MOHLTC and the OHA began a collaborative process, through the JPPC, to address multi-year funding for hospitals and develop a prototype performance agreement framework (PAF) for use between the MOHLTC and the hospitals that will spell out the fundamentals of their relationship crucial to a constructive and effective operational environment and will support the delivery of the best affordable patient care.[87]

This follows an initiative in 2000 when the MOHLTC and the OHA prepared a report entitled ***Partners in Health: Forging An Accountability Framework*** (FAF). The report identified three benefits from developing an accountability framework:

- fostering a shared understanding among partners or roles and responsibilities;
- strengthening productive relationships by building bridges for communication; and

[86] Harber/Ball, "Redefining accountability in the Healthcare Sector" (Lecture, Insight Health Policy Summit Toronto 2003, 29-30 April 2003).

[87] *Supra* note 17.

- promoting commitment to a continuous improvement approach.[88]

The report promoted five steps to building an effective framework:

I. Defining clear roles and responsibilities;

II. Agreeing on performance expectations or goals;

III. Establishing credible reporting requirements;

IV. Establishing reasonable review and adjustment processes with a focus on improving performance through supportive assessment and feedback; and

V. Demonstrating the levels of performance attained.[89]

The development of a successful PAF between the MOHLTC and the hospitals is an essential first step in establishing a dependable working relationship that will enable the parties to work together in a constructive manner that clarifies expectations and ensures consistent behaviour. The FAF laid out five relationship principles designed to build confidence and trust:

- support each other to fulfil their respective mandates;
- commit to open and transparent communications
- commit to regular and timely feedback;
- follow through on communications made; and
- inform or consult with one another prior to making changes in commitments.[90]

The PAF needs to clearly enunciate the roles and responsibilities of both parties to the PAF including shared areas of responsibility.

The current JPPC initiative on Multi-Year Funding and Performance Agreement Process will presumably build on the work of the FAF in the development of the PAF.

The JPPC Steering Committee retreat on the PAF reached the following conclusions:

- The retreat strongly endorsed a collaborative approach among government, hospitals, and the OHA to developing performance agreements between hospitals and government.
- The retreat stressed the importance of developing hospital performance agreements in the context of a healthcare system approach.

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[88] *Supra* note 85.

[89] *Ibid.*

[90] *Ibid.*

- The retreat advocated for a quality improvement focus to the performance agreement process, including avoiding blame in the case of unsatisfactory performance and emphasizing ways to seek improvement in performance.

- Domains of performance selected by participants in the retreat included the following:

  - ✓ Access to care
  - ✓ Patient Outcomes
  - ✓ Workplace Health and Safety
  - ✓ Financial Health of the Organization
  - ✓ Health System Integration
  - ✓ Governance and Management Practices

To pursue the work, the JPPC created four committees and six working groups.[91] The successful completion of the PAF in late March 2004 should establish the basis for the effective creation of a strong, clear accountability framework. This combined with the greater certainty arising from the stability of a new multi-year funding regime should form the foundation for a new era of accountability.

In addressing this undertaking, it is sobering to reflect on the observations of the Auditor General of British Columbia, who carried out a review of Performance Agreements between the BC Ministry of Health Services and the Health Authorities. He reported:

> "We found that the ministry and the health authorities generally understand that they are to be held accountable for meeting the requirements set out in the agreements. However, there are different views as to what the agreements are intended to achieve."[92]
>
> "Performance agreements should be clear on who is accountable and what they are accountable for. The roles and responsibilities should be consistent with the overall governance structure to ensure there are no contradictions about who is in charge, who sets the directions, who makes the decisions, who monitors progress and who is accountable for what. In our view, the current agreements lack the necessary consistency with the health sector's governance structure.[93]

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[91] *Supra* note 17.

[92] *Supra note 11,* at 15.

[93] Ibid at 17.

Most useful in contemplating the above was the following finding:

> "We also found that the process used for establishing the performance agreements had been rushed, not allowing enough time for full collaboration between the ministry and the health authorities…. In future, a more collaborative process, based on a relationship of mutual trust and respect is needed so that agreements are fair and realistic."[94]

4. Hospital Accountability

(i) Elements and Questions

The Broadbent Report suggested the application of accountability involved three elements, all of which should apply to hospitals:

1) taking into account the public trust in the exercise of responsibilities;

2) providing detailed information showing how responsibilities have been carried out and what outcomes have been achieved; and

3) accepting responsibility for outcomes, including problems created or not corrected by an organization or its officials and staff.[95]

In successfully confronting accountability, hospitals must successfully address four questions:

- Who is accountable?
- For what are they accountable?
- To whom are they accountable?
- How is accountability achieved?

With the answers to these questions established, the hospitals must turn their attention to success in their operations in order to meet the requirement so their accountability undertakings are addressed.

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[94] Ibid at 3.

[95] Panel on Accountability and Governance in the Voluntary Sector (Broadbent Panel), *Building on Strength: Improving Governance and Accountability in Canada's Voluntary Sector - Final Report*, (February 1999) (Chair: Ed Broadbent).

For the hospital sector, accountability must span governance, finance and management of programs and operations. Hospitals have accountability to different interests – the Corporation, the MOHLTC, the patients and the community served. They are accountable for:

- ensuring the best interests of the Corporation;
- ensuring the best interests of patients
- their fiduciary responsibility to the MOHLTC for delivery of the provincially-mandated health care program;
- efficient and effective management of their finances to maximize care within the resources provided to the satisfaction of the MOHLTC and the community served;
- the community served for quality, accessibility, service efficiency and effectiveness within existing resources; and
- the community served for advocacy on behalf of the hospital.

(ii) Board Accountability for Ensuring the Best Interests of Patients

The Board has a clear accountability for the patients that it is serving and central to that, is the dependence of the patient on the mix of professional skills and services available for treatment. There are several aspects to ensuring the patient receives quality care consistent with the human, financial and technological resources available. For the patient's needs to be effectively addressed, the Board must be satisfied that the hospital has the ability to deliver to the patient the skills and treatments required or identify alternative arrangements. Appropriate accountability would require that the board is confident that:

- Management has in place results based performance frameworks that:
  - ✓ identify results, measure and report outcomes;
  - ✓ measure and assess demand;
  - ✓ encourages or utilizes "the balanced scorecard" or similar approach;
  - ✓ clearly outline the roles and responsibilities of the service providers and the support groups;
- Management has a strong utilization management program to identify, address clinical efficiency issues;
- Random audits are carried out of health record practices to maintain the integrity of hospitals coding practices;
- Management has in place relationships with other health providers so that the patient can be served in the most effective means by the health care system.

(iii) Board Accountability to the MOHLTC

The Board has both a program delivery and financial accountability and responsibility to the MOHLTC.

a. Delivery of provincially mandated health care programs:

- All provincially mandated programs are fully defined, quantified, funded and delivered meeting quality performance requirements;
- The hospital is addressing the best interests of the patients within the approved and funded provincial programs;
- Management and the MAC have in place provider human resource plans to ensure that the human resource capability is sufficient for the defined mission;
- Utilization management program;
- Auditing and enforcing good health record practices;
- Effective resources demand has been anticipated and measured;
- Programs are not expanded with out identified resources in place to manage them;
- New programs are not introduced without MOHLTC approval and sufficient funding to sustain the program;
- Updated co-ordination and integration programs and initiatives with other health care providers in the region.
- Rural and Northern Framework hospitals report on progress/completion of directed consolidations of governance and management structures and strategic alignment of programs and service.

b. Financial Accountability:

- The Board must have in place results based performance frameworks and report to the MOHLTC:
    - ✓ identifying measurements and reporting on results and outcomes;
    - ✓ status of human resource programs and planning proposals;
    - ✓ access and demand management issues;
    - ✓ comparing and contrasting results with formally established targets;

- Provide three to five year financial plans;
- Provide annual budgets on a balanced and limited growth basis;
- Introduce new programs or program expansion only after consultation with MOHLTC and with sufficient funding in place;
- Utilize uniform financial reporting systems developed with the MOHLTC;
- Utilize information technology that meets the uniform reporting requirements of the MOHLTC;
- Report on integration and service sharing with other hospital and non-hospital health providers;

(iv) Board Accountability to the Community Served

The Board has a responsibility to ensure that the community is served efficiently and effectively in accordance with its health mandate. The Board must be accountable to the community served for:

- ensuring that it is meeting the best interests of the patients as above;
- providing public education as to:
  - ✓ the scope of the provincially mandated health care programs provided;
  - ✓ the quality of services available within the hospital;
  - ✓ services available in the wider health care system;
  - ✓ effective and efficient uses of services available (when it is appropriate to use emergency facilities and when other options should be employed);
- reporting on the financial performance status of the hospital;
- reporting on the mandate and future planning for the hospital;
- ensuring that no unilateral action is taken which may impact on other parts of the system without full consultation with the MOHLTC:
- the efficient and effective use of locally provided funding and volunteered services.

While several hospital Boards have recently established a policy on Director Acknowledgement of Accountabilities[96], we would anticipate that these will be superseded by the forthcoming Performance Agreements, which will establish mutual accountabilities between the hospital Board of Directors and the Minister of Health and Long-Term Care.

[96] *Supra* note 24

5. MOHLTC Accountability

Accountability is not a one-way street in the health care system. While the hospitals have a responsibility to the MOHLTC for the management of public resources in pursuit of the delivery of quality health care programs to the public, they, in turn, must be able to rely on the MOHLTC to accept its accountabilities. This was recognized by the Minister in his statement to the Standing Committee on February 16, 2004:

> "Accountability means being answerable for our actions, not just our good intentions. We need clearer performance targets, greater transparency, and better lines of communication. And let me be clear: accountability isn't a burden we place on others, it's a responsibility we all accept and share – and I include this government and my ministry."[97]

From the MOHLTC, this should result in reliable funding processes, well-understood mutual accountabilities in the performance agreement and system leadership initiatives to assist the hospitals in the development and implementation of effective operations.

The MOHLTC must answer the same four questions posed to the hospitals above, to ensure measurable accountability between them.

The MOHLTC must be an effective enabler to the system to have the tools in place to successfully monitor good hospital governance and accountability. Key areas for MOHLTC leadership include:

- working with the hospitals to develop uniform information management systems for both the operational and financial reporting essential to the advancement of benchmarking, best practices and reliable financial accountability;
- enabling and mandating opportunities for inter-hospital and hospital agency collaboration in the delivery of common services;
- working with hospitals and providers to align incentives to encourage a more collaborative work environment;
- the provision of stable and predictable funding.

[97] *Supra* note 19.

Mark Stabile, in his paper Options for Health Care Reform in Ontario, captures one of the consistent issues that complicates effective reform in the system:

> "The current funding structure of the health care system consists of several separate entities none of which fully consider the impact of their actions on the other sectors of the health care system."[98]

This concern has been underlined by the Minister Smitherman in his speech to the Economic Club of Toronto on February 24, 2004 when he addressed the non-system issue:

> "Our vision is of a system where all providers speak to one another in the same language, where there are no longer impenetrable and artificial walls between stakeholders and services: a system driven by the needs of patients, not providers."[99]

The MOHLTC is accountable for:

- overseeing and accounting to the public through the government and legislature on the effective delivery of health care in Ontario;
- establishing strategic plans and policies to advance public health care in the Province of Ontario;
- effectively communicating strategic plans and priorities to the health care system;
- within their resources providing financial support to the health care system in Ontario;
- accounting for funds expended by the MOHLTC to support the public health care system;
- establishing acceptable accountability frameworks with hospitals.

While the accountabilities between organizations must be clear, there must be recognition that accountability is a two-way street and that the success of any accountability regime requires that parties to the PAF must be able to rely on each other's undertakings if the outcomes are to be of value. The success of the accountability of the hospitals to the MOHLTC is very much dependent on the framework established between them and the leadership of the MOHLTC in establishing consistent behaviours and dependable indicators. That is essential to permit accountability to be used as a tool for enhancing management practices and bringing about organizational change to improve performance.

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[98] Mark Stabile, Ph.D., "Options for Health Care Reform in Ontario" (Paper presented to OHA, December 2001) [unpublished].

[99] George Smitherman, *"Transforming Health Care in Ontario"*, [Speaking notes, Economic Club of Toronto, 24 February 2004).

While most of the burden falls on the hospitals to gear themselves up to properly account for their performance, their accountability processes will be of little use if they cannot be tested against the performance of others and create opportunities to develop best practices and new benchmarks.

The MOHLTC, as the principal funder and planner for the health care system, must use its authority and leadership position to work with the hospital sector through the OHA, as with the JPPC initiative to devise policies and practices that encourage and enhance behaviours consistent with sound accountability frameworks in the hospitals.

The accountability initiatives that MOHLTC should undertake jointly with the hospitals to advance the quality of accountability include to:

- develop with the hospitals a uniform accounting system to ensure reliable financial reporting;
- develop dependable multi-year funding practices as an active management tool for increased accountability that would provide the following benefits:
  - ✓ improved timelines for system planning and reconfiguration;
  - ✓ greater fiscal predictability for the government;
  - ✓ improved working conditions for health care workers;
  - ✓ improved patient care access and quality;[100]
- encourage the use of the balanced scorecard approach;
- the MOHLTC should review the *Public Hospitals Act* to ensure that it advances and does not hinder the accountability process with hospitals;
- the MOHLTC should work with the OHA to establish a common information technology platform for timely development of financial reporting, financial management controls and benchmarking initiatives;
- support and encourage hospitals to replace fee for service with a value based remuneration system to align financial and clinical objectives in hospitals.

[100] OHA Multi Funding Working Group, *Stability and Sustainability, OHA Multi Funding Working group Report*, (18 October, 2002) at ii.

CHAPTER 6: Conclusions

This discussion paper is intended to be a catalyst for discussion and foundation for action as OHA initiates a process of governance renewal and participation in implementation of Performance Agreement Frameworks to enhance mutual accountability between the hospital sector and MOHLTC.

The journey to good governance and well-understood accountabilities cannot be made overnight. Optimal functioning will require important system reforms such as good information systems, predictable funding arrangements, alignment of incentives among providers and focused policy leadership. Hospital Boards will need to focus more on their internal operations, such as: appropriate patient accessibility; best practices; management performance; value for money; efficient and effective utilization; retention and recruitment policies, and on external matters such as co-ordination of services with other health providers (agencies, hospitals, etc.) to maximize ready, quality access for patients while avoiding duplication and poor co-ordination.

Many positive actions have been taken by hospitals and the MOHLTC, but there is still a long way to go before we can be confident that the residents of Ontario are getting needed, quality services delivered in an affordable, effective and efficient manner. The fact that we cannot complete the journey to good governance and well-understood accountability overnight is no reason to delay the process. Indeed, the commitment of the MOHLTC and the hospitals to embark on the journey to good governance and well-understood accountabilities will help drive the reforms that will produce the optimal result for patient care in Ontario.

So where and how to begin the journey? We would contend that the Accountability journey is well underway through the comprehensive and systematic joint MOHLTC/OHA process under the auspices of the JPPC targeted for completion in March 2004.

Based on our experience, we would contend that there are two fundamentals of approaching governance renewal:

- the establishment of understandable and user friendly templates to assist and guide individual hospitals in renewing their governance policies, practices and by-laws;

- a comprehensive, systematic and facilitated process to engage Directors in actively debating the fundamentals of governance and to build their ownership of and commitment to renewed governance policies and processes.

The two go hand in hand as fundamental building blocks for success in changing the way that our hospitals are governed. The best templates are of little value if Boards do not understand them and/or have an opportunity to make them their own. Our experience has demonstrated that a systematic facilitated process of dialogue, debate and consensus building among Directors and between the Board and Management is essential to building an effective governance policy framework and an effective governance team.

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