

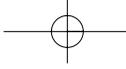
INTRODUCTION

This is the story of Ontario's Health Services Restructuring Commission. Established in 1996, the commission (HSRC) was one of the first in a series of such bodies, provincial and federal, set up to find solutions to worsening problems in health care — principally resistance to change, painful cost containment and ineffective accountability. Preceded by the more cerebral National Forum on Health (1994-97), Ontario's HSRC (1996-2000) was followed in 2000 and 2001 by a series of provincial bodies in Quebec (Clair Commission), Saskatchewan (Fyke Commission) and Alberta (Mazankowski Council).¹ Subsequently the Standing Senate Committee on Social Affairs, Science and Technology (2002), chaired by Senator Michael Kirby, reported the results of its two-year study of the state of health care in Canada. Weeks later, sole commissioner Roy J. Romanow reported on the work of the Royal Commission on the Future of Health Care in Canada (2002). Canadian health care, provincially and nationally, does not want for study nor for well-informed advice on approaches to solving its problems.

Created with a four-year mandate by legislative authority in 1996, the HSRC differed from its successor provincial commissions and councils by virtue of its having the unprecedented and seemingly unconstrained authority to restructure public hospitals. This power of direction, binding on the hospitals affected, was coupled with the more conventional responsibility to recommend to the government, through the minister of health, other changes necessary to make the provision of health services in Ontario more efficient and effective.

The HSRC's 12 volunteer commissioners took their role as agents of change very seriously. Private citizens with widely differing backgrounds and experience, drawn from communities throughout Ontario, they worked hard and long. For much of the time they were exposed to the unaccustomed glare of media attention and sometimes to the vocal ire of people affected by their decisions. Their emolument of one dollar a year was well and truly earned.

The goal? To foster progress toward the development of a genuine, rational, health care system in which hospitals work efficiently both with one another and with all the other players that together provide the range of services needed by vulnerable people facing or experiencing risks to their health.



Did the commission succeed? Were the four years of toil worthwhile? Given the glacial pace of change in health care, a scant four years after the commission's "sunset" is too soon to say. Certainly the goal of an efficient and optimally effective health-services system² in Ontario or in any other province remains some way off.

But some progress has been made. As a direct result of the commission's work, many previously competing acute-care hospitals in most of the province's urban municipalities have been consolidated, allowing the new institutions to provide higher-quality services more cost-effectively. Investments have been made in the expansion of home-care services and the creation of more nursing-home places to accommodate hospitalized patients categorized as ALC (alternative level of care) — people who would be cared for better and less expensively somewhere other than in an acute-care hospital. Most importantly, perhaps, the HSRC broke the mould of the status quo ante; it used its power to demonstrate conclusively that structural and operational improvements *can* be made in the delivery of health services in Canada, even in cautious Ontario, where the iconic status of health care qualifies proposals for change as the political equivalent of the "third rail."

This account of the HSRC's work has been written by the three people closest to the action. Duncan Sinclair was chair of the commission for the full four years. Mark Rochon was its chief executive officer for the first two tumultuous years of hospital restructuring. Peggy Leatt served as CEO subsequently, during the increasingly uphill struggle to develop viable strategies for a government whose zest for change in health care policies was, by then, quickly eroding.

Although the ideal of cold objectivity has been kept front and centre throughout, the authors are keenly aware of how difficult it is to "see ourselves as others see us," to quote Robbie Burns. Therefore, caveat emptor! Others may interpret differently the motives, debates, decisions, events, results and reactions during and since the commission's life span, from April 1996 to March 2000. But this is the frank and unvarnished view of those who were at the centre of the action.

Why tell the story now? Although it is five years since the HSRC shut its doors, it is only two years since its planning horizon of 2003 was reached. Thus the results of its work can be considered current.

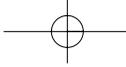
During its four-year mandate the commission:

- > changed the landscape in 22 of Ontario's urban and regional communities by ordering amalgamations and "takeovers," creating larger hospital organizations capable of greater quality and economies of scale; closed

- 31 public, 6 private and 6 provincial psychiatric hospital sites, prompting major expansion, province-wide, in home care and facility-based long-term care
- > articulated and publicized its vision of Ontario's future health care system as a series of interconnected, integrated, regional community-based health systems
 - > suggested ways and means of coordinating mental health services, region by region, and integrating them with other hospital- and community-based health and social services
 - > recommended the organization of small rural and northern hospitals into networks
 - > developed strategies to achieve (1) a capacity for effective health information management; (2) reform of primary health care; (3) integration of health services in communities committed to achieving it; (4) the capacity to measure and assess improvements in the performance of health care delivery and to enhance its productivity and accountability; (5) the establishment of academic health science networks; and (6) more effective governance, by the province, of the restructured health care system

As with seeds, some ideas germinate slowly, some erratically and others not at all. All must find fertile ground, water and warmth. When the commission completed its mandate we thought that telling its story immediately would do more harm than good. Candid description of still current events and debates could well have reinforced what we perceived then to be a backlash against the rapid change the HSRC had forced, particularly on hospitals. Exhaustion, brought on in part by the fast pace, took the form of growing resistance to change on the part of hospitals, other players and the government; resolve stiffened against even the idea of considering new ways of organizing the provision of health services.

Although we do not perceive the ground and climate to be any more welcoming of change now, four years on, it is improbable that the telling of the commission's story will have a negative effect on the halting progress of the reform of Ontario's health care system or, more accurately, the creation of a genuine health care system in Ontario. It may embolden some to take those safely-out-of-sight reports down from their dusty shelves to test the receptivity of new policy-makers and decision-makers to the ideas and strategies they contain. At the very least, students and observers of health care in Canada will have the opportunity to share,



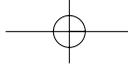
before they fade to fantasy, our recollections of a novel approach to reforming the way in which health services are organized and provided in Ontario and of an exhausting and tumultuous yet fascinating experience.

We begin with some history, if that is not too grand a term for such recent times, of the circumstances that applied in the mid-1990s, circumstances that led to the establishment of the HSRC with its unprecedented power to order the restructuring of Ontario's public hospitals. First we offer an explanation of why the newly elected government created the commission, thereby giving a small group of volunteers control over highly contentious decisions with the potential to affect, if not determine, that government's political future.

We then describe the HSRC's transformation from a legislative concept to a real entity with staff, an office, contracted consultants, various strategies, and, most importantly, a plan and schedule for tackling its mandate. Central to everything, of course, was the forging of relationships, with the minister and the Ministry of Health,³ with hospitals and other organizations within the various health-provider communities, and, primarily through the media, with those members of the public who were keenly interested in and would be affected by our decisions.

We follow with a description of the policy context in which the commission was established — what was in place to guide its work and, more significantly, what was not. Centrally important was the HSRC's articulation of its vision of a genuine health-services system — how it would meet the needs of Ontarians into the twenty-first century. It was essential that this vision be complemented by a series of policy guidelines relating to the “sizing” of community-based services such as long-term and home care, to ensure that alternative kinds of care would be available to patients affected by the changes that the commission would make in the acute-care and other hospitals.

Although we would have preferred otherwise, our initial focus was hospital restructuring. Central to this work — phase I — was our understanding of voluntary governance. We devote a chapter to the strengths and weaknesses of this concept, and to how the HSRC approached and dealt with boards of directors that represented the communities served by Ontario's public hospitals and their legal owners. We then move on to hospital restructuring itself, the basic principles we applied, our approach, the difficulties we faced in dealing with both urban and rural hospitals, and the overall outcome. We include a number of specific examples as the story of phase I unfolds but have resisted the temptation to include a



blow-by-blow account of our interactions with the various hospitals. This may be a disappointment to those looking for the “inside story” regarding their community and its hospitals, but that was never our intention in writing this book. Confidentiality was promised to those affected, and that promise has been kept.

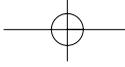
Chapter 5 describes what constituted the HSRC’s greatest frustration and worry — forging a better and timelier linkage between our binding directions to hospitals to change and action by the government to implement our recommendation for concomitant changes in other health services, principally investments in home and long-term care. That linkage, of course, constituted the government’s constraint on the commission’s legislated power to order hospital restructuring. We describe some of the difficulties we faced at our bureaucratic and political interfaces, how we and those on the opposing side dealt with them, and the outcomes that were achieved.

In chapter 6 we turn to phase II, the HSRC’s second two years, during which it turned its attention to the development of recommendations to the government on how best to begin creating a health-services system out of what is colloquially referred to as a “field of silos.” We discuss our analysis of why the system’s many autonomous constituents — acute care; tertiary/quaternary care; academic medicine; continuing care; rehabilitation, psychiatric, specialty and other hospitals; family and specialist physicians; independent health facilities; home care; nursing homes (the list is a long one) remain so poorly coordinated. We describe our establishment of a priority order of strategies to foster greater collaboration and coordination among these many players in order to achieve greater continuity of care for patients and their families, who have little interest in institutional or professional autonomy.

Communication with the public and with hospitals and other health care providers was very important to the HSRC and to the achievement of our goals. We devote chapter 7 to the development and execution of a strategy to explain and “market” our work. We deal particularly with the role played by the media in describing to the general public the commission’s role and responsibilities as well as the reasoning behind our decisions.

In chapter 8 we discuss what turned out to be our time-consuming involvement with the courts, often referred to within the commission as our “legal practice,” where our directions to some hospitals were rigorously tested.

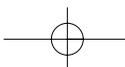
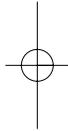
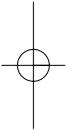
In chapter 9 we review things as we now see them, measured against the planning horizon of 2003, and offer advice on what might be done differently the

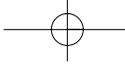


next time a government responsible for the governance of health care turns to an arm's-length, apolitical body to do things that, for whatever reason, it cannot do itself. The lessons we learned during the HSRC's four-year mandate are set out in chapter 10 — what was accomplished, what was changed, what was and was not effective.

We conclude by analyzing the implications of the commission's work for public policy on health care in Canada and the lessons that policy-makers might learn from the experience. Here, we draw heavily on work done subsequent to the HSRC's sunset by provincial bodies in Quebec, Saskatchewan and Alberta, and nationally by Senators Kirby and colleagues and by Roy Romanow with his Royal Commission on the Future of Health Care in Canada, to demonstrate the broad consensus of expert opinion on how to proceed with the creation of a new policy framework to preserve and enhance what Canadians call medicare.

This, then, is the story of Ontario's Health Services Restructuring Commission as experienced from within.





NOTES

- 1 Commission d'étude sur les services de santé et les services sociaux (2000), Commission on Medicare (2000) and Premier's Advisory Council on Health (2001), respectively.
- 2 System is defined as a "complex whole, set of connected things or parts, organized body or material or immaterial things" (*The Concise Oxford Dictionary of Current English*, 1976).
- 3 During the commission's tenure, the name of the Ministry of Health was changed to the Ministry of Health and Long-Term Care.

