RESEARCH PAPER

Inconsistent Governance Structures for Health and Social Services Limit Service Integration for Patients with Complex Care Needs

Des structures de gouvernance incohérentes pour les services de santé et les services sociaux limitent l'intégration des services pour les patients ayant des besoins de soins complexes

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Abstract

This paper describes how health and social services are governed and organized across Canada for two patient groups. Governance configurations and governance proximity between primary care and priority health and social services varied markedly between provinces. While the need for integrated service delivery has been made a clear priority during the COVID-19 pandemic, the potential of Canada's healthcare systems has not yet translated into coordinated and integrated care for health services, much less for health and social services. It is time to act on the policy recommendations from commissioned reports over the past two decades that focus on comprehensive, community-based care.

Résumé

Cet article décrit comment les services de santé et les services sociaux sont régis et organisés au Canada pour deux groupes de patients. Les configurations de gouvernance ainsi que la proximité de la gouvernance entre, d'une part, les soins primaires et, d'autre part, les services de santé et sociaux prioritaires varient considérablement d'une province à l'autre. Bien que la nécessité d'une prestation de services intégrés ait été clairement établie comme une priorité pendant la pandémie de COVID-19, le potentiel des systèmes de santé du Canada ne s'est pas encore traduit par des soins coordonnés et intégrés pour les soins de santé, et encore moins pour les services de santé et sociaux. Il est temps de donner suite aux recommandations stratégiques des rapports commandés au cours des deux dernières décennies, lesquels mettent l'accent sur les soins communautaires complets.

Introduction

In 2016, researchers within Canada's Primary and Integrated Health Care Innovations Network were looking to spread or scale up integrated care delivery solutions across provincial and territorial jurisdictions, but could not find any current description of how health and relevant social services were governed and organized in different Canadian provinces. The aim of this paper is to address that gap by describing and comparing the formal macro-level governance structures and strategic policies in Canadian provinces that pertain to comprehensive (i.e., a range of health and social services), integrated (i.e., support linkages and exchange) care for patients with complex care needs.

From the multiplicity of definitions of integration (Armitage et al. 2009), we used the following working definition: service integration refers to the ensemble of policies and procedures that support linkages and efficient exchange among institutions that deliver complementary services. Originating in business and manufacturing – where service integration gave major players a competitive economic advantage – service integration has become a sought-after goal to achieve both cost savings and effectiveness in health systems since the 1980s (Goldsmith 1994). An early assumption in the healthcare integration literature is that common governance in a single-payer or single-owner system makes it easier to align

different entities or providers (vertical integration) (Conrad and Shortell 1996; Goldsmith 1994; Robinson and Casalino 1996; Shortell et al. 1996).

The concepts of integration in healthcare have shifted from focus on the acute care hospital as the organizing entity toward community-based services (Evans et al. 2013; Kodner 2009). Reflecting on this shift, Valentijn et al. (2013) posit that primary care is the appropriate locus to conceive comprehensive healthcare integration because primary care is the point of first contact and purports to use a person-focused and biopsychosocial approach. In Canada, achieving comprehensive primary healthcare requires the integration of primary care (predominantly medical) with other health services, social services and community supports. The ensemble of policies and procedures at a macro level (system-level integration) provides a starting point for other forms of integration among organizations (meso) and service providers (micro) (Valentijn et al. 2013).

In its broadest sense, "governance" is defined as clarifying "who does what (or who should do what), which people and roles are involved, their areas of authority and responsibility, and how decisions are made" (Villeneuve 2017: 1). We assume that authority and responsibility are reflected through formal governance structures and that service integration is facilitated when services are in proximate governance units. We indicate the provincial-level governance structures that pertain to primary care and priority services identified for two target populations: children and youth (0–25 years) with high functional health needs and community-dwelling older adults (≥ 65 years) experiencing functional decline (Dionne et al. 2023). In keeping with the principle of vertical integration, we assume that service integration will be facilitated when services share strategic and operational policies under the same governance authority (proximal governance) and will be more challenging when they operate under different governance structures (distal governance).

Providing a descriptive portrait of the governance structures of the provinces is intended to identify governance environments that are likely to be supportive of integrated delivery solutions that link health, social and community services and to facilitate cross-jurisdictional learning and comparative research.

Methodology

Between September 2017 and September 2018, team members (NF, SZ) conducted a scan of government websites in the 10 Canadian provinces to identify the formal ministerial governance structures and any strategic policies that pertain to primary care and integration between health and social services (Appendix 3, available online at www.longwoods.com/content/27185). These websites were used as there are no existing databases that consolidate this information. We included any information about provincial governance structures and strategic policies that was feasibly accessible from public government websites and was relevant to priority services for the two target populations. The information for each province was summarized and presented to a key government informant. Key government informants were identified by the research team members in each province and were usually the decision

makers within the provincial ministry of health. Interviews were brief (30 minutes to 1 hour, approximately) and were focused on confirming the summary and identifying any gaps in the description. Based on these interviews, the information was amended to reflect the situation at the time the information was collected.

A second scan, from June 2019 to January 2020 (AA), focused on the "governance distance" between primary care and the 15 priority services for our two complex care target populations of children and youth and older adults. These are populations managed in primary care clinics, requiring connection to health and social services to optimize functional health but whose care processes are likely to be relevant to other patient groups (Dionne et al. 2023). One member of the team (AA) obtained the detailed organizational chart (organigram) of each provincial ministry of health closest to September 2018. The organigrams were predominantly obtained from publicly available websites. When they were not available from public websites, they were obtained from key informants from the ministry of health (we use "ministry of health" to refer to this generic function, recognizing that the proper name differs by province). Priority services that were in the same organizational unit as primary care were considered "very proximal," those in different organizational units but under the same level of hierarchical authority as primary care were "proximal" and those under a different hierarchical authority were "distal." Services that fell under the authority of another ministry were "very distal."

The provincial summaries were generated by research associates and were read independently by three senior team members (JH, CS, YC) who immersed themselves in the summaries and then crystallized observations to detect cross-provincial similarities, differences and patterns pertaining to integration of services (Borkan 1999). Initial insights were challenged to ensure that they were based on the available data and not pre-existing positions or personal knowledge. The senior team members summarized the similarities and differences as they related to priority service areas for the two target groups. The findings were presented to the larger research team to assess the accuracy of the results. This study received ethical approval from the Research Ethics Committee of the Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal.

Results

The quantity and detail of publicly available information on government websites varied substantially across provinces. The information was most easily accessible (i.e., little effort to find and retrieve from websites) and up to date (in decreasing order) in British Columbia (BC), Quebec (QC), New Brunswick (NB) and Ontario (ON); somewhat accessible in Alberta (AB), Saskatchewan (SK) and Newfoundland and Labrador (NL); and the least accessible in Prince Edward Island (PEI), Manitoba (MB) and Nova Scotia (NS).[1]
Key informants consistently remarked that the summaries based on the websites were out-of-date and might not reflect current structures.

The publicly available organigrams also varied considerably in detail. The most detailed organigrams were in BC, QC and NB and the least detailed were in PEI. According to our key informants in PEI, the lack of detail reflected an intentional policy orientation toward health promotion rather than disease management. It was challenging to find the entity responsible for overseeing the provision of some of our priority services in organigrams.

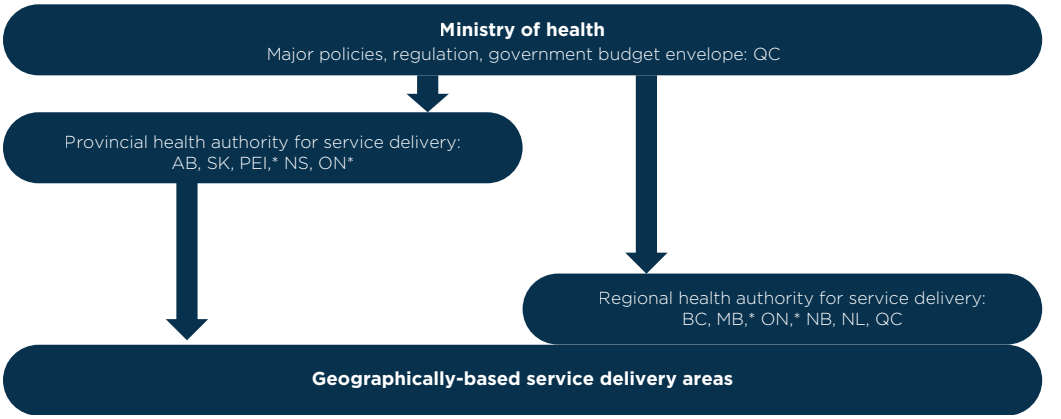
Centralized vs. decentralized structures of macro-governance

All the provincial ministries of health maintained a distinction between health system oversight (regulatory and funding allocation) and governance of health service delivery. Sometimes these distinct functions were assumed by separate governance entities. For instance, Alberta Health had the regulatory function and Alberta Health Services oversaw health service delivery. In MB, PEI and ON, health service delivery was under crown corporations that were accountable to the ministries of health but were independent entities with their own governance structure. In QC, both oversight and governance of service delivery were centralized within the Ministère de la Santé et des Services sociaux.

Integration of services was a recurring policy concern across provinces. Historically, the focus has been on the integration of medical services from primary through tertiary levels. The main policy instrument used in all provinces was geographic zoning of service delivery. In some provinces, the intention to integrate was reflected in the naming of the zones: Integration Areas (SK); Local Health Integration Networks (ON) and Centres intégrés de santé et de services sociaux (QC). The scope of service delivery governed geographically pertained mostly to medical care, but in rural service delivery areas, the scope could extend to medical and social services as we observed in SK, MB and QC (e.g., in SK, an executive director of primary healthcare in rural areas may also have the authority and responsibility for broader services, including home care, public health and mental health).

In some provinces, in addition to macro policies at the ministry level, there were regional authorities with the authority for funding allocations and priority setting for the geographic zone and regional organization of service delivery (devolution). There seemed to be an increasing trend toward consolidating health authority at the provincial level with only service delivery being zoned geographically. AB was the first province to replace regional health authorities with a province-wide health authority in 2008. Several provinces followed suit: PEI in 2010, NS in 2015, SK in 2017 and ON in 2019 (outside the study period). QC also abolished the 18 regional health authorities in 2015 and concentrated authority at the Ministère de la Santé et des Services sociaux but did not create a new governance entity; planning, delivery and resources were decentralized to 34 geographically zoned Centres intégrés de santé et de services sociaux. The use of crown corporations as the accountable organizations for health services delivery in MB, ON and PEI was also a mechanism for concentrating authority at the ministry of health. Figure 1 illustrates the provinces that had consolidated vs. regionalized health authority in 2019.

FIGURE 1. Structure of provincial health authority and regionalization of service delivery in 2019



The 2019 structure of governance, authority and health service delivery shows provinces with authority consolidated at the provincial level (left), provinces with regional authority at the geographic delivery zone (right) and provinces with governance delegated to an independent crown corporation (*).

A governance innovation in BC in 2013 created a First Nations Health Authority that was not geographically bounded and that designed, managed and funded the delivery of First Nations health programs and services, including the federal services formerly provided by Health Canada. Another non-geographic health authority oversaw and coordinated province-wide agencies and programs with specialized health missions (e.g., cancer, autism, emergency services).

Governance oversight for primary care

Table 1 names the ministry of health for each province. The name of the provincial ministry of health in six of 10 provinces suggests governance scope beyond classic medical and public health services: wellness (PEI, NS), social services (QC), community services (NL) or long-term care (ON). MB's Ministry of Health, Seniors and Active Living (since 2016) suggests the broadest scope. If we presume that broader scope of governance suggests potential for broader service integration, then MB's governance environment should be conducive to the integration of health, social and community services, at least for older adults.

Table 1 also names the entity where primary care is located. Although all ministries of health refer to primary healthcare, the scope refers to the first-contact community-based delivery models that we identify as primary care. The organizational nomenclature of governance oversight differs from province to province. We, therefore, use the generic terms first, second and third level to denote the different hierarchical levels of governance oversight. For instance, in NL and NS, the "department" is the highest level of governance (equivalent to ministry), whereas in others, "department" refers to a sub-unit. In BC, branches are under divisions, whereas in SK and NL, divisions are under branches. Primary care is usually located at the third level of governance, except in BC and PEI, where it is at the second level of governance suggesting higher importance within the ministry of health.

TABLE 1. Names of provincial ministries of health and levels of hierarchical governance for primary healthcare in 2018

Province	Name of ministry of health (first level of governance)	Second level of governance	Third level of governance
British Columbia	Ministry of Health	Primary Care Division	Primary Care Strategy, Policy and Quality
Alberta	Alberta Health	Health Workforce Planning and Accountability Division	Primary and Community Health Branch
Saskatchewan	Ministry of Health	Connected Care Services Branch**	Primary Health Services Branch
Manitoba	Health, Seniors and Active Living (2016)	Mental Health and Addictions, Primary Health Care and Seniors	Primary Health Care Branch
Ontario	Ministry of Health and Long-Term Care**	Mental Health and Addictions, Primary Health Care and French Language Services**	Primary Health Care Branch
Quebec	Ministry of Health and Social Services	Direction générale des affaires universitaires, médicales, infirmières et pharmaceutiques	Direction générale adjointe de l'Accès, des Services de proximité et des Effectifs médicaux
New Brunswick	Department of Health	Health Services and Francophone Affairs Division	Primary Health Care Branch
Nova Scotia	Department of Health and Wellness	System Strategy and Performance Division	Primary Health Care Branch
Prince Edward Island	Ministry of Health and Wellness	Regional Family and Community Medicine and Hospital Service	Primary Care and Chronic Disease Branch
Newfoundland and Labrador	Department of Health and Community Services	Population Health Branch	Primary Health Care

**Time stamped to 2018 – names changed subsequently.

The vast majority of primary care services in Canada were delivered privately by autonomous physician-led family practices and were not under the purview of the ministry of health. We observed, however, that several provinces had governance mechanisms that facilitated the engagement of physician leadership in primary care service delivery. Both BC's Divisions of General Practice and QC's Direction régionale de médecine générale provided a forum for physicians to organize the planning and delivery of primary care around local practice priorities. In AB and SK, leadership of primary care networks and integration areas was assured jointly by the ministry, zone (AB) and physician leads. MB engaged physician leaders and other health professionals in governance through an entity called Shared Health.

Governance proximity between primary care and priority services

Most of the services ranked as priority services for children and youth and older adults fell under the governance of the ministry of health. Notably, five services ranked in the top 10 for

both groups: home care; mental health and addictions services; timely transitions between urgent, emergency and acute care; respite care; and medication reconciliation by community pharmacies. Medication management in community pharmacies falls under the governance of professional associations rather than under the ministry of health, so we excluded it from further analysis. Table 2 shows the governance distance for the nine remaining services, grouped by overall governance proximity to primary healthcare (though proximity varies by province). We present the results and their implications for integration by governance proximity.

The priority services most proximal to primary care were chronic disease management; home care; mental health and addictions services; and urgent, emergency and acute care. In most provinces, integrated care solutions should be the easiest for these services, and their similarity across provinces should facilitate the spread of innovations. Home care is often subsumed under the label of "continuing care" but the description corresponds to home care, which was under the same second-level governance as primary care (i.e., proximal) in four provinces (MB, ON, NS, PEI). In the other five out of 10 provinces, home care and primary care were under different second-level governances (distal). Home care and primary care governance locations needed to be inferred for SK. The provinces with the greatest overall governance proximity between primary care and priority services were MB, ON, NB, NS and PEI. If common governance facilitates operational integration, then these provinces may be the most supportive of integrated care solutions for both elders and children and youth.

Chronic disease management was the priority service most consistently proximal to primary care across the seven provinces where it was named explicitly. This was also an explicit policy priority in the Maritime provinces. Chronic disease management was also a professional competence of primary care health professionals, which may support clinical integration across organizational boundaries.

It is striking that mental health and addictions services was usually a stand-alone unit in most organigrams, and was proximal to primary care in MB, ON, NS, NB and NL. Although the notations in Table 2 indicate low proximity in BC and AB, both provinces had a governance entity for mental health and addictions at a high level to provide broad authority and oversight. BC had a dedicated Ministry of Mental Health and Addictions in addition to the unit for mental health in the ministry of health. AB had a dedicated office for an associate minister under the Ministry of Mental Health and Addiction, who reported directly to the minister of health, in addition to its unit for addiction and mental health (distal from primary care).

The findings that acute and emergency care was proximal to primary care in QC, NS and NB need to be interpreted with caution because the priority expressed was for a timely and smooth continuum of services between urgent, emergency and acute care. Urgent care services are usually a function of primary care with no governance unit named "urgent care"

TABLE 2. Governance proximity between primary healthcare and priority services for children and youth and older adults with complex care needs

	Most proximal overall				Proximal			Most distal	
Province	**Chronic disease management**	**Home care**	**Mental health and addictions services**	**Urgent, emergency and acute care**	**Pre/postnatal care**	**Respite care**	**Palliative care**	**Telehealth**	**Health information systems**
British Columbia	***	*	*/X	*	*	*	*	**	**
Alberta	*	*	*/**	*	*	*/X	*	~	*
Saskatchewan	**	*	*	*	*	*	*	X	X
Manitoba	***/**	**	**	*	~/*/X	**/X	*	~	*
Ontario	**	**	**	*	*	**	**	X	*
Quebec	*	*	*	**	*	*	*	~	*
New Brunswick	***	*	**	***/**	X	*/X	**	*	*
Nova Scotia	**	**	**	***	*	**	***	*	*
Prince Edward Island	***	**	*	***	**	**/X	**	*	*
Newfoundland and Labrador	**	*	**	*	*/X	*	~	X	*/X
Ranking in target group	Child #n/a Older #1	Child #9 Older #2	Child #3 Older #5	Child #4 Older #8	Child #5 Older #n/a	Child #10 Older #3	Child #n/a Older #6	Child #1 Older #n/a	Child #2 Older #n/a

Governance proximity: *** = very proximal; ** = proximal; * = distal; X = very distal (in another ministry); ~ = information could not be inferred; / = governance shared.
Child = children and youth; older = older adults.
Shaded cells = information needed to be inferred.

within their scope of services. Governance of pre/postnatal care, respite care and palliative care was also generally proximal to primary care but with large variances between provinces, and often needed to be inferred (shaded cells).

The services most distal from the governance of primary care were health information systems including telehealth, a priority service for children and youth. The governance location of telehealth could not be inferred in five out of 10 provinces (AB, MB, QC, NS, PEI), but its governance was in a separate ministry in SK, ON and NL, and within the ministry of health for BC and NB. Not surprisingly, the largest governance distance from primary care was for social services that were mostly governed by other ministries. Nonetheless, we did see some priority social services within ministries of health of different provinces: adult day programs (in all provinces except MB, NB), educational support programs (ON, PEI), housing (AB, ON, MB) and nutrition support programs (MB, QC, NB).

Discussion

Our intent was to understand formal provincial-level governance structures to facilitate the scale and spread of integrated service delivery solutions across provincial and territorial jurisdictions. In attempting to understand these governance structures, we experienced many limitations. Firstly, our underlying assumption that service integration will be facilitated when services share strategic and operational policies under the same governance authority has theoretical merit but has yet to be definitely demonstrated with empirical evidence. Our intent to review governance structures and strategic policies as publicly displayed on government websites was limited due to the quantity, level of detail and accuracy of the information on websites (Stewart et al. 2023). There was inconsistent access to current organigrams on government websites and inconsistent detail and nomenclature in the organigrams and strategic policy descriptions across provinces. Due to resource constraints, we were unable to conduct more extensive searches or additional key informant interviews in each province to improve the accuracy of the findings. What we were able to discern may, therefore, not have reflected current governance structures. Despite these limitations, this high-level snapshot of the provincial-level governance structures for community-based health and social services illustrates the oft-quoted axiom of Canada having 14 different health systems (i.e., 10 provincial and three territorial health systems and one federal health system for Indigenous populations). We observed not only different governance configurations but also continuous major restructuring of governance, which makes it challenging to create up-to-date cross-provincial portraits. Nonetheless, this snapshot shows that service integration is a common and enduring concern in the health sector, with geographic zoning being the principal policy instrument for service integration. In 2000, health authority was mostly devolved to the geographic zone level, but since 2008, we observed a trend toward consolidation of authority at the provincial level. We also observed considerable variation between provinces in governance proximity of primary care to priority services for children and youth with complex care needs and older adults experiencing functional health decline. We discuss these further below.

While there was consistency across provinces in the use of geographic zoning to address service integration, we observed considerable experimentation with the sizing of geographic zones and centralization versus geographic devolution of governance authority. Regional health authorities were instituted across Canada in the 1980s and 1990s to consolidate the services offered in a territory, to shift from hospital-based to community-based care and to be more responsive to the needs of the population (Lewis and Kouri 2004; Marchildon 2015, 2016). Geographic zoning has led to improvements in service coordination, although the promise of integration has yet to be achieved (Barker and Church 2017; Bergevin et al. 2016). AB led the way with centralizing authority but decentralizing service delivery to geographic zones, but the size of geographic zones is far from stable. Even ON – the latecomer to regionalization in 2006 – moved to even smaller sub-zone delivery areas in 2015, only to be restructured yet again in 2019 under a single new authority providing oversight to five geographic regions. Fierlbeck (2016) argues that regional governance restructuring meets

political ends more than policy ends by disrupting the influence of established stakeholders: more churn than change. Perhaps government experimentation with geographic zoning of authority and service delivery and finding cost efficiencies deflects from the consideration of policy instruments, such as integrated budgeting (Shortell et al. 2014), or investing in interoperable health information systems (Kizer and Dudley 2009) that would support improvements in care.

One development in governance structures that we observed was the engagement of physician leadership in BC and QC through general practice geographic delivery areas and the engagement of physician leaders at executive levels for service delivery areas in AB and SK. Although community-based care was a stated objective of regionalization, the delivery of many services through autonomous physician-led family practices left primary care out of the regional equation. The integration of physicians into health system structures is one of the thorniest issues in achieving service integration (Bergevin et al. 2016; Shortell et al. 1996). Physician governance falls to the associations that govern the profession and to provincial colleges that issue licences to practice. Yet, within provinces where primary care renewal models are the norm (AB, ON, QC and NB) (Haggerty et al. 2023), the ministry of health had a greater role in governance and leverage for service integration. Despite AB's success in involving more than 90% of physicians in primary care networks (PCNs) and engaging physician leaders as co-executives of PCNs, recent attempts by the government to impose payment changes on physicians (Lee and Anderson 2020) point to the ongoing tension between ministries of health and physician organizations that negotiate on behalf of their members.

There are encouraging governance and strategic policy shifts in various provinces that are expected to enhance the connection between health and social sectors. MB's Shared Health (established in 2018) had a broad purview that included recruitment and retention of health human resources (including physicians), information and communication systems and clinical coordination and planning. The restructuring of PEI's health system reflected a policy intention to de-silo health services delivery from upstream determinants of health including social services. NL's Health-In-All-Policies approach for all ministries may have created a supportive governance environment for innovative programs that integrate education support, housing and income support with primary healthcare and other community-based services.

What can we discern from our analysis of governance proximity between primary care and priority services for our target populations? If our premise is true that more proximal governance contributes to common governance oversight for unified operational policies in the single-payer Canadian health systems, then our findings would suggest that MB, ON, NB, NS and PEI offer provincial governance environments that might be more conducive to testing integrated care solutions across health and social services. Integrated care solutions should also be the easiest between primary care and chronic disease management; mental health and addictions services; home care; and urgent, emergency and acute services, which are consistently in close governance proximity. Delivery solutions that integrate

care for these services may also have the greatest potential for cross-jurisdictional learning because they appear consistently in provincial organigrams and they share a legacy of federal policy initiatives (Health Canada 2006; Kirby and Keon 2006; Romanow 2002). We also acknowledge that our focus on formal provincial-level governance proximity is only one consideration among many (e.g., physical and social geography) in finding successful integrated care solutions.

Conclusion

We recognize that we have created an impressionistic and static 2019 portrait of governance structures that are in constant flux. Comparative information was not simple to obtain; details varied across provinces, and it was often out-of-date; and the level of detail varied across provinces. Although we validated the summaries with key informants in each province, in some cases this was a single person. It was challenging to base our findings only on available data in 2018, and it gave us a deep appreciation for the importance of data and information availability. If getting detailed and up-to-date information was difficult for a research team with dedicated (if limited) resources, what must it be like for citizens to understand their own health system or for policy makers who want to engage in cross-jurisdictional learning? Integrated care solutions in one province may require considerable governance re-arrangements to function in another. The only current mechanism for exchanging ideas for health system improvement is through federal, provincial and territorial ministerial meetings, and these meetings are highly politicized. If we are to advance cross-jurisdictional learning, there is a need for a less politicized forum for sharing innovation among provinces. Looking at this through the lens of two different target populations with complex needs allowed us to circumscribe the priority services that needed to be connected, but the priority services do not always correspond to identifiable governance units. The impact of inconsistent health and social governance structures across provinces has been brought into sharp relief during the COVID-19 pandemic.

Policy recommendations from commissioned reports over the past five decades have reflected a public commitment to the principles of the *Canada Health Act* (1985) (i.e., comprehensiveness, universality, public administration, portability and accessibility), while embracing the understanding that achieving health for all Canadians requires integration of health and social services, shifting from institutionalized to community-based, interprofessional care (Epp 1986; Health Canada 2006; Lalonde 1974; Romanow, 2002). Despite these calls for change, the hospital-based, physician-centric system of care has remained intact. The status quo of hospital-based systems is not meeting the needs of people with complex and chronic conditions, and adding more funding to existing healthcare structures and administrative systems is not a solution. There are no quick fixes. But what is clear from our results is that continuous administrative restructuring of health systems that fails to align health and social services under proximate governance structures is unlikely to achieve the long-standing policy goal of integration.

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Note

1. All provinces will be named in order of west-to-east geographic location unless indicated otherwise. Not all provinces are identified in each example.

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