

Article

A Good Decision? The New Arrangement for Health Care in Ontario

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Abstract

Recently, a new government of Ontario decided to replace the province's health care system with a different approach to the management of health services. The major portion of the change meant that several regional health agencies would be combined into a single health authority. The decision mirrored one that had been made ten years earlier in Alberta, which allows for an opportunity to assess the decision of Ontario. This paper compares the performance of the single authority in Alberta and the regional authorities in Ontario for the past ten years. A superior performance by Alberta would suggest that the single authority is preferable to the regional arrangement and that Ontario had made a sound decision. A contrary result would give reason for believing differently. The comparison indicates that the Ontario government might have been too hasty in opting for a single health authority.

Résumé

Récemment, un nouveau gouvernement de l'Ontario a décidé de remplacer le système de soins de santé de la province par une approche différente de la gestion des services de santé. La majeure partie du changement signifiait que plusieurs organismes régionaux de santé seraient regroupés en une seule autorité sanitaire. La décision reflétait celle qui avait été prise dix ans plus tôt en Alberta, ce qui permet d'évaluer la décision de l'Ontario. Le présent document compare le rendement de l'administration unique en Alberta et des administrations régionales de l'Ontario au cours des dix dernières années. Un rendement supérieur de l'Alberta donne à penser que l'autorité unique est préférable à l'entente régionale et que l'Ontario a pris une décision judicieuse. Un résultat contraire donnerait des raisons de croire différemment. La comparaison indique que le gouvernement de l'Ontario a peut-être été trop hâtif en optant pour une seule autorité sanitaire.

Key Words: Ontario, Alberta, health authorities, comparison, regional approach

Mots-clés : Ontario, Alberta, régies de la santé, comparaison, approche régionale

Introduction

Nearly three decades ago many of Canada's ten provinces accepted the idea that regionally based governance and service delivery might be the key to addressing major problems with health plans. A decade later, nine of the ten provinces had put into place regional health authorities (RHAs). A few years after this point the remaining province of Ontario followed suit with their own version of regional health agencies. High expectations accompanied the introduction of the authorities, but disappointment eventually set in. Though the shortcomings of regionalization were not well documented, it was believed by governments that the authorities fell well short of achieving their objectives. Health services continued to operate without much awareness of a more integrated health system and the role of the local citizenry in health care remained limited. It was also felt that reallocation of scarce resources towards care in the community recorded only minimal success and rivalries among authorities acted to restrict sharing of new procedures and ideas (Duckett 2011; Marchildon 2015; Premier's Council 2019). As a result, some provinces reduced the number of authorities in the regions while others went with a single authority.

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In 2019, a recently elected conservative government in Ontario chose to end the experiment with regionalization in the most heavily populated province in Canada. The Local Health Integration Networks (LHINs), the name of the regional authorities in Ontario, would be replaced by a single authority arrangement. Interestingly, a little more than a decade ago, Alberta had replaced nine RHAs with a single health care agency called Alberta Health Services (AHS). By comparing the performance of Alberta's AHS and Ontario's LHINs over the past decade, it should be possible to gain some appreciation of the recent decision of the Ontario government. If the comparison favours the AHS and the single authority approach, then Ontario has probably made the right decision. If the regionalization of the LHINs seems preferable, then Ontario's plans may need adjusting. The paper finds that the government of Ontario should consider building changes in their new arrangement that favour a regionalized approach to health care.

Background

The two health-care arrangements to be considered have ties to regionalization. Within the context of health care, regionalization refers to attempts to better the performance of government health plans through processes of decentralization and centralization. Decentralization occurs by establishing units or authorities throughout the provinces that are responsible for the management, funding and at times the actual delivery of health services to citizens within the regional boundaries. The act of centralization, which is in some provinces is not wholly developed or even adopted, involves the newly-established authority assuming the ownership of health care services that were once under the control of local boards and agencies (Barker and Church 2017). The intent of these two related actions is to produce a health care system more efficient and more sensitive to the needs of the population.

The LHINs represented Ontario's attempt to apply regionalization. In 2006, 14 regional bodies were established throughout the province to manage and finance health care in their area. Administrative and planning bodies had preceded the LHINs – no government can literally operate a health care system from a single centre – but these entities lacked the influence and resources of the LHINs. Under this new arrangement, the LHINs would be accountable to the provincial ministry of health, and indeed services such as physician care and prescription drugs would remain with the ministry. Interestingly, the province decided against the centralization component of regionalization. Ownership would remain with the boards and agencies, a decision that reflected a belief that stripping local bodies of any role would not sit well with the relevant community.

As for Alberta, regionalization first appeared in 1994 with 17 regional health authorities and prevailed until 2008, when the 9 authorities in place at the time were reduced to a single authority. Like the LHINs, AHS was and remains accountable to the Minister of Health through a provincially appointed board and responsible for the planning and delivery of a broad spectrum of health care services including acute care, continuing care, home care, cancer, mental health, addictions, ambulance and public health – but not for primary care and pharmaceutical expenditures, which stayed with the health ministry. The authority is divided into five geographic service zones and has twelve advisory councils, an arrangement that resembles the regional approach. However, the zones and councils are without the autonomy and consequential influence of regional health authorities. Finally, unlike the

LHINs, possession of the relevant health care resources (e.g. hospitals) was first transferred to the set of regional authorities and then to AHS.

Method

The proposed comparison of the two approaches to managing health care constitutes an attempt to discover which approach best responds to the health-care concerns of the new Ontario government. A consideration of various pronouncements and statements indicates that the government has four major concerns (Ontario Ministry of Health and Long Term Care 2019a, 2019b). One is the financial sustainability and overall efficiency of health care services, a worry that arises from excessive expenditures and unwise spending assignments. A second concern focuses on the absence of an integrated system of services, and a third is patients who may be less than fully satisfied with the quality of health services. The final concern centers on the lack of accountability found in health care operations. These four concerns are used to guide the assessment of AHS and the LHINs.

In most instances the assessment pertains only to matters under the control of the LHINs and AHS. This means, for example, addressing the issue of spending involves expenditures of the LHINs and AHS and not those of the entire department. To do otherwise would detract from a fair and accurate assessment of the two entities.¹

Spending and Sustainability

Modern health care systems have many worthwhile goals but underlying any ambitious plan for health care is the concern for spending and sustainability. The first pronouncements announcing the replacement of the LHINs with a central authority addressed the issue of spending. The Progressive Conservative government expressed worries about the relatively high administrative costs of the LHINs and the sustainability of the overall health system (Ontario Ministry of Health and Long Term Care 2019a; Ontario Ministry of Health and Long Term Care, 2019b). It also noted that health care spending represented 42% of the total expenditures of the provincial government, a percentage deemed unacceptable. (Ontario Ministry of Health and Long Term Care 2019a, 3). The government also mentioned its preference for a community-based system (Ontario Ministry of Health and Long Term Care 2019a). An emphasis on community-based care typically entails a greater share of the spending going to home care and other services that reduce the need for hospitalization and placement in long term care facilities.

One approach to comparing AHS and the LHINs on spending is to examine increases in expenditures. Between the fiscal year 2008/09, the first year the LHINs had control of their budgets, and 2017/18, spending by Ontario's 14 regional health authorities grew from \$20.7 billion to \$27.2 billion (Ontario Ministry of Finance/Treasury Board Secretariat 2009, 2018), which represents an increase of 31%. The average annual rate of growth for these years was 3.1%. Between 2009/10, the first year AHS had control of its budget, and the fiscal year 2017/18, spending by the central authority rose from \$10.5 billion to \$14.8 billion, an increase of 41% and an average annual increase for the eight years of 4.4% (Alberta Health Services 2010, 2018). Spending adjusted to make AHS budgets more comparable to those of the LHINs shows that expenditures for AHS increased from \$7.7 billion in 2009/2010 to \$10.9 billion in 2017/18. This represented an increase of 42%.² The average annual spending increase, at 4.4%, was the same as the unadjusted percentage.

At first glance, then, it seems ill-advised for the government of Ontario to have followed in the footsteps of Alberta if control of spending was a major goal. The LHINs performed better than AHS when it came to limiting expenditures. This consideration of spending, though, may be incomplete. A look at spending controlling for population growth and inflation reveals a lessening of the differences in percentage points.³ With the adjusted list of expenditures, AHS recorded an increase in expenditures of 2.3% from 2009/10 to 2017/18 and an average annual increase of only 0.5%. Comparable results for the LHINs were 1.8% increase in expenditures and an average annual increase of 0.2% or basically zero. Also important to mention is that the greater wealth in Alberta most likely played a part in creating higher expenditures in Alberta (Statistics Canada 2017). But while higher expenditures in Alberta might be somewhat accounted for by the larger GDP per capita, its relatively younger population would suggest that expenditures should be lower (Statistics Canada 2020).

As with most governments, the new government of Ontario wants to place a greater emphasis on community-based services. This preference supports the belief that this type of shift might produce more appropriate care at a lower cost. It may also enhance the level of patient satisfaction because patients typically prefer receiving care at home rather than in hospitals or long term care facilities (Sinha and Bleakney 2014). An analysis of spending on a full range of community-based services by the LHINs shows that the portion of their budgets allocated to these services increased during the period 2008/09 to 2016/17 from 14.9% to 19.2% (Ontario Ministry of Finance/Treasury Board Secretariat 2009, 2017).⁴ After making adjustments to the AHS budget to ensure comparability with the LHINs budget, the data show that the percentage allocated to home and community care in Alberta increased from 13.8% in 2009/10 to 17.8% in 2017/18.⁵ As can be seen, the percentage point increases in the shares for the two provinces are similar (and so are the percentage increases when calculated). These figures exclude consideration of spending on long term care facilities, for it is questionable whether this type of care reflects the commitment to prevention typically found in the community-based approach to health care. When included in the definition of community-based care, the share of total spending for this type of service in Ontario increased from 28.3% in 2008/09 to 31.5% in 2016/17, a growth rate of 11.3%. In Alberta, the increase was from 23.9% to 27.7%, a rate of growth equal to 15.9%.

A final fiscal issue to consider is administrative expenses. This issue figured prominently in the rationale for disbanding the LHINs. Ontario's new government observed that each LHIN had a "full senior management team and back office support" and that "over time some of this work ha[d] become duplicative" (Ontario Ministry of Health and Long Term Care 2019b, 2). It is also asserted that the province in the past half-decade had spent nearly a third more on administration than the average for all of Canada (Ontario Ministry of Health and Long Term Care 2019a, 3). The latest data, which is for 2017/18, show that administrative costs for the LHINs represented 5.8% of total expenditures, a percentage higher than the average percentage for all of Canada, at 4.5% (CIHI 2019a). The percentage for AHS fell below the average, at 3.3% (CIHI 2019b). An examination of percentages from 2013/14 to 2017/18 shows a small decrease for both Ontario (from 6 % to 5.8%) and Alberta (3.4% to 3.3%); this translates into a 3.3% decrease for Ontario and 2.9% for Alberta. The data thus suggest over time there is little difference between the two agencies – both managed to reduce their administrative costs expressed as a percentage of total expenditures, albeit only slightly. However, Alberta retains the edge in costs when looking at costs in any single year,

and there are reports that AHS has indeed taken actions to address this type of cost (Office of the Auditor General of Alberta 2017a, 16). But it should be remembered that administrative expenditures are not necessarily wasteful. An agency may have relatively high administrative expenditures because of ambitious health arrangements requiring careful supervision (Mueller, Hagenars, and Morgan 2017); such may have been the case with the LHINs with its attempt to get closer to the provision of care and the concerns of patients and the community.

The preceding analysis of spending by the LHINs and AHS shows that both gained a hold on public expenditures and reallocated spending in the desired direction, with the LHINs scoring better on overall spending and two agencies recording changes that are near the same on reallocation of home and community care (but admittedly AHS recording a larger change if long term care costs are also considered). As for administrative costs, AHS continued to spend relatively less on this budgetary item while the LHINs secured a slightly greater percentage decrease in spending. Upon viewing these results, the most appropriate conclusion appears to be that the small differences in spending and reallocation of resources suggest that there is little gain for Ontario in moving towards a single authority arrangement.

Integration

When explaining its decision to replace the LHINs, the Conservative government of Ontario stated that the province's health system had "become fractured and disconnected" and that "care end[ed] up being delivered in silos." The government's new approach would ultimately "provide seamless access to various types of health" (Ontario Ministry of Health and Long-Term Care 2019b, 1). An advisory group to the new government concurred with this critique of the LHINs, saying that the "pathway through the [Ontario] health care system is often not a straight and simple line" (Premier's Council 2019, 5). These claims all relate to the importance of offering an integrated health system, one that would eliminate barriers that deprived patients of a smooth journey through the health care system and one that steered patients to the right type of care. A comparison of the experience of AHS and the LHINs with integration is thus crucial for ascertaining the most appropriate approach for the new Ontario government.

Success with integration efforts might be attained by measuring changes in the ease with which patients pass through the steps or transition points in the health system (Health Quality Ontario 2013, 12). At each point, an applicable measure usually can be identified. A possible first step is an individual seeking care for a newly discovered ailment that without redress from a community service might develop into a problem requiring hospital care. An integrated system would work to ensure the availability of the appropriate service. A relevant measure at this point is ambulatory care sensitive conditions per 100,000 population, which identifies hospitalization for conditions that might have been avoided with earlier care in the community. In 2010/11, the first year of the availability of relevant data, the rates were 360 hospitalizations per 100,000 for AHS and 320 per 100,000 for the LHINs, indicating that the LHINs had more success with integration at this point (CIHI 2019c, d). In 2017/18, the two agencies recorded reductions - 338 patients for AHS or a 6.1% decrease and 314 patients or a 1.9% decrease for the LHINs. With the LHINs, then, Ontario maintained its advantage in integration at this point, though the data also show that positive changes in the measure for the two provinces favoured Alberta. Another transition point in a patient's journey might be the need for hospitalization following a diagnosis provided in

an emergency department. The hope here of emergency departments and their patients is for quick admission and avoidance of obstacles in hospital units. A relevant integration measure here is hours spent in an emergency room before gaining admission. In 2014/15, 90% of the relevant patients in Alberta's emergency departments were admitted within 28 hours, while the comparable number for Ontario was 30 hours (CIHI 2019e, f). By 2018/19, the number of hours has declined slightly for Alberta and increased by three hours for Ontario (27.1 hours for AHS and 33.3 for the LHINs).

Once in the hospital, patients receive treatment and then most become candidates for discharge. At this transition point a further integration measure, alternate level of care (ALC), becomes relevant. The ALC refers to the percentage of inpatient days that beds were being used by those able to leave the hospital; they fail to do so because of insufficient support in the community. In 2013/14, the ALC percentage for AHS was 10.1%; by 2017/18, it had increased to 17.4% (Alberta Health Services 2018, 26). By comparison, the ALC percentage for the LHINs decreased from 14.3% in 2011/12 to 13.9% by 2015/16; it then increased continuously to its rate of 15.5% in 2018/19 (Health Quality Ontario 2019, 4). The data show that both provinces have experienced increases in ALC rates, but that the increase has been greater in Alberta.

A final measure of integration available for comparison looks at readmission rates for hospital patients. These are patients who have been treated in a hospital for any ailment within thirty days of a hospital discharge. A successfully integrated system would have a relationship between hospitals and the community that would help to limit this type of occurrence. For instance, hospitals might forward care information to the patient's family doctor to ensure continuity of appropriate care. In 2014/15 readmission rates for all former patients was 8.9% for AHS and 9% for the LHINs. Four years later, the rate in Alberta had increased to 9.5% and in Ontario to 9.6%, a marginal upward movement for both agencies (CIHI 2019g, h). Readmission rates for specific care like surgery and medical care have recorded similar results.

Various interpretations can be made of the results. It might be said that overall AHS performed better than the LHINs because it recorded higher rates of positive change with two of the measures and the same result for a third measure. However, the LHINs do much better on the indicator that might be considered the greatest interest of the new Ontario government. The government has given special attention to what is called "hallway health care" or the practice of placing patients in hospital corridors because of the lack of beds (Premier's Council, 2019). Results for ALC suggest that the government's selection of a single authority system might make hallway medicine an even greater problem.

An important quality of an integrated health system is the ability to guarantee the timely provision of health services. A seamless health system, as stated earlier, is pursued because it heightens the probability that patients will receive the right care when it is most needed. Examining specific health procedures and determining whether they are provided within an acceptable amount of time thus gives some idea of the degree of success with integration.

A set of five procedures have been identified by federal, provincial and territorial governments as being of high priority for all provinces and territories, and benchmarks have been established to indicate "the amount of time that clinical evidence shows is appropriate to wait for a particular procedure" (Ontario Ministry of Health qtd. in CIHI 2017a, 5). A province or territory may be entirely successful by ensuring that 100% of these procedures are provided within the approved amount of time. Alternatively, the percentages for one or

more of the procedures may also be less than 100% and hence indicate that work needs to be done to provide a more integrated system. The five procedures are hip replacement, knee replacement, hip fracture repair, cataract surgery, and radiation therapy, with benchmarks having been established for each of the procedures.

Table 1 shows the percentage meeting the benchmark figure in 2014. The mark of '>' means at least a five percentage-point increase over the same figure in 2014, the mark of '<' means at least a five percentage-point decrease, and the absence of a mark means no substantial change (CIHI 2015). So, for example, 87% of hip replacements in Alberta met the benchmark in 2014 and the accompanying mark of '>' meant at least a five percent-point increase over the 2010 figure. As can be seen, AHS achieved increases of more than 5% for three of the five procedures, while the equivalent result for the LHINs was only one (and one decrease). This difference indicates a faster rate of improvement in Alberta but at a rate that fails to equal the performance of the LHINs on any of the five procedures.

Table 1 Benchmark Results for Select Procedures, 2014

Procedure	AHS	LHINs
Hip Replacement	87% >	88%
Knee Replacement	81% >	86%
Hip Fracture Repair	82%	84% >
Cataract Surgery	71%>	81%<
Radiation Therapy	97%	99%

Source: CIHI. 2015. *Wait Times for Priority Procedures in Canada*, 7.

Table 2 provides comparable figures for 2018 (CIHI 2019i). As can be seen, AHS recorded three results that declined by five percentage points or more, while the LHINs recorded two. Moreover, a comparison of the two tables shows that percentage point decreases in the three AHS procedures were substantial and easily surpassed those for the LHINs. To be sure, AHS recorded the only increase of 5% or more and in so doing managed to overtake the LHINs when it comes to hip fracture repairs (and now also has the same percentage for radiation therapy). However, this seems insufficient to counter the relatively large declines in three of the five procedures for Alberta.

Comparisons involving Alberta and Ontario for two additional procedures – CT and MRI scans – are also possible, though not in terms of benchmarks. Rather, the measures capture the days necessary to serve 90% of patients requiring scans. For AHS, the wait time for providing CT scans to 90% of those requiring the service increased from 36 days in 2012 to 92 days in 2016. Comparable figures for Ontario are 32 days and 41 days. For MRI scans taken in Alberta, the wait time decreased from 261 in 2012 to 242 in 2016. For its part, Ontario saw its number increase from 86 to 99 (CIHI 2017a, 12, 17). Clearly, there are

differences that support the case for the LHINs, even if it is true that AHS recorded a decline in wait times for MRI scans and the LHINs recorded a relatively small increase.

Table 2 Benchmark Results for Select Procedures, 2018

Procedure	AHS	LHINs
Hip Replacement	70% <	84%
Knee Replacement	66% <	79% <
Hip Fracture Repair	94% >	87%
Cataract Surgery	49% <	70% <
Radiation Therapy	100%	98%

Source: CIHI. 2021 *Wait Times for Priority Procedures in Canada*

As with spending and sustainability, there are instances in which it is difficult to separate the LHINs and AHS on their respective attempts to integrate health services. But the scores for ALC rates and wait times for CT and MRI scans are clearly differentiated in a way that suggests both higher quality care with the LHINs and important implications for a government seeking to put an end to hallway health care. A similar conclusion with respect to the quality of care can also arise out of an examination of the five high priority procedures.

Patient Experience

A further concern of the Ontario government is the experience and satisfaction of patients with health care services. In its initial statements, the new government of Ontario expressed its wish for “patient centered community care” and for a plan to deliver “local” care close to residents. The same focus was evident in the claim of the new Ontario minister of health, who said that patients would “finally have a say in their own health care journey” (Ontario Ministry of Health and Long-Term Care 2019a, 5). There was also the following official statement: “the government is transforming the public health care system to improve patient experience” (Ontario Ministry of Health and Long-Term Care 2019b, 1)

An accepted method for capturing patient satisfaction and experience is the use of patient surveys. In 2016, the Commonwealth Fund group, an American health organization, conducted a survey in eleven countries to determine the views of adult patients on various aspects of a health care system (CIHI 2017b). The survey provided results for the participating countries, and in Canada’s case it also generated outcomes for the individual provinces – a decision that facilitates looking at results for the two provinces of interest and comparing them. However, there was not a comparable survey taken in earlier years to allow for an appreciation of the degree of progress towards satisfying patients. Moreover, it was not clear whether any differences between the two provinces in the 2016 survey were statistically significant. But the survey did determine whether differences between the individual provinces and the average result for all eleven countries were statistically

significant, so one might compare the two provinces indirectly by revealing how each did in relation to the average score of the participating provinces on each of the relevant questions. For the ten questions that pertained to AHS and the LHINs, the results show that the two agencies achieved similar results on seven of the queries; for the remaining three questions, Alberta achieved the higher result.

In 2017, the Commonwealth Fund group carried out a survey of residents aged 65 and over in countries that participated in the 2016 survey (CIHI 2018). Again, separate results were obtained for the ten Canadian provinces, making it possible to compare indirectly the performance of Alberta and Ontario by seeing how they fared in relation to the average score for all competing countries. Once again, ten questions were deemed relevant to the two agencies, four of which showed no difference. Of the remaining six, Alberta secured a higher result on five of the questions and Ontario on one. The most that can be said of these survey results is that it appears that Albertans might have been a little more satisfied with their health system than Ontarians were with theirs at the time of the survey. However, it is impossible to determine whether this edge amounted to an improvement in health care in Alberta or reflected a trend that preceded the advent of AHS and the LHINs.

Interestingly, another survey, a Canadian one called Health Care in Canada, includes a few questions that compare Alberta and Ontario (plus a couple of other regions) in surveys of citizens conducted in 2013/14 and 2018 (McGill 2018). It is thus possible with the two surveys to gain some idea of the contribution of the two agencies to the quality of care. On one question dealing directly with quality of care, Alberta reveals a small amount of positive change over the four-year period and Ontario none. Another query that addresses timely access to care show both provinces doing worse but with Ontario less so. A final question to consider asks whether major or even a greater rebuild is required to improve the health system. The percentage increase of respondents in both provinces answering in the affirmative is basically the same. On balance AHS and the LHINs come out about even, a finding consistent with the Commonwealth survey.

For the newly elected government of Ontario – and for most governments – patient satisfaction has a quality that goes beyond meeting individual health needs. Patient satisfaction also involves providing patients and the larger community with opportunities to influence government health policies. The new Ontario government’s commitment to a permanent Minister’s Patient and Family Advisory Council demonstrates an appreciation of the patient as part of the policymaking process. The Council serves to “provide advice on key care priorities” and “drive meaningful changes to provincial health care planning, programs, and policies.” Its members are private citizens who have experience with the provincial health care system (Ontario Ministry of Health and Long-Term Care 2019b, 3).

Both the LHINs and AHS made efforts in the past decade to ensure patient and community engagement in health-care planning and operation. In the case of the LHINs, each regional authority facilitated the involvement of advisory bodies representing Francophone and Indigenous peoples. In later years, the LHINs did the same for patients and families (and a province-wide version of the patient and family committee was also put in place). The larger community was also invited to be part of a process for developing three-year plans for all LHINs. As well, some of the LHINs and health care providers such as hospitals created special arrangements to provide for the input of families and others. For instance, citizen panels were employed to gain patient and community feedback on specific proposals, and the position of community advisor was set up for government and health provider groups

anxious to gain the perspective of users of health care services. Individual LHINs also hired personnel skilled in encouraging and managing public engagement.

As for AHS, it too provided for patient participation in the workings of its operations. Twelve geographic health advisory councils acted to bring the voices of local communities into healthcare decision making. Additionally, four advisory councils (Addictions and Mental Health, Cancer, Seniors and Continuing Care, and Sexual Orientation, Gender Identity and Expression) offered advice, and a body was established to encourage the participation of Indigenous peoples. Complementing these advisory bodies were individual patient and family advisors, who used their experiences with health care to give direction to all sorts of community and governmental entities grappling with the challenges of health care. Also noteworthy was a committee of the AHS board dedicated to matters of community engagement. And at the provincial level the government extended the role of the provincial Ombudsman to include health care and mental health. In this capacity, the Ombudsman assisted Albertans to resolve issues they had with health services and mental-health care.

All in all, it appears that the two agencies took similar actions to help ensure that the consideration of initiatives and proposals for change in the health care system was not a closed process. A decision to proceed with either a regional or single authority approach would not rest on a consideration of efforts to engage patients and the larger community. Less obvious is whether differences prevailed on whether the input had any real effect on decision-making.

Accountability

A last concern of the Progressive Conservative government in Ontario deals with establishing effective accountability arrangements throughout the province's health system. Accountability refers to a relationship where responsibilities are clearly assigned to entities answerable to the carrying out of their new duties. It also requires the capacity for measuring performance of duties and the issuing of some type of sanction for unacceptable performance and reward for good performance (Thomas 1998). The Ontario government has already begun to build a foundation for achieving a high level of accountability. The legislation authorizing the new health care system provides for accountability agreements between the minister of health and the single health authority. The single authority in turn offers "a central point of accountability and oversight for the health care system" (Ontario Ministry of Health and Long Term Care 2019c), and finally the health units or teams found throughout the province are to be "held accountable for improving patient experiences and people's health" (Ontario Ministry of Health and Long-Term Care 2019b, 2). All these attempts to secure accountability suggest that the new Ontario government would be interested in seeing how single and regional authorities compare when handling accountability issues affecting health care.

Roles and Responsibilities

The first step in any attempt to establish accountability is to clearly convey the allocation of roles and responsibilities (Thomas 1998, 352.). An agency can hardly be answerable for its actions when confusion and uncertainty accompany any assignment of duties. The same holds for situations in which actions seemingly contradict or go against the formal allocation of responsibilities. For example, the body assigning tasks to another agency elects to carry

out these duties or overturns a decision made by the entity with the formal authority. In both Alberta and Ontario, the relationship between the central ministry of health and AHS in one instance and the LHINs in the other acted to weaken attempts at achieving accountability.

In Alberta, an audit of the province's health system by the auditor general, released in 2017, uncovered evidence of practices and actions that fell short of the requirements of accountability. For instance, the central department of health involved itself in operational issues assigned to AHS (Office of the Auditor General of Alberta 2017a, 25-26). In 2012, the department announced the establishment of several family care clinics even though some would be under the authority of AHS. The latter had not been informed of this initiative until shortly before the time of the announcement and some elements of the proposed clinics also proved inconsistent with practices of the regional body. More generally, the provincial auditor found that the ministry regularly violated section five of the *Regional Authorities Act*, which lists the responsibilities of AHS and makes clear that the agency has "final authority" over these matters (Service Alberta 2020). One effect of this behavior was to produce at times two bodies existing side-by-side and carrying out the same responsibilities, a result that put into question the viability of AHS.

The audit also found that an absence of clarity served to hinder efforts at achieving accountable relations. For instance, the auditor general discerned that the department failed to provide a clear framework for monitoring the various parts of primary care, especially in relation to the performance of the primary care networks. Without this clarity, there was little way to determine whether AHS and the networks were meeting objectives and thus being fully accountable (Office of the Auditor General of Alberta 2017a, 39; Office of the Auditor General of Alberta 2017b, 74-77). Findings like this caused the auditor general to conclude that there was "a lack of clear roles and responsibilities for major entities in the health system" and that it was "not clear who is responsible for the overall cost and quality of care that individuals received over time" (Office of the Auditor General of Alberta, 2017a, 7).

In Ontario, accountability agreements enabled the ministry to require that the LHINs carry out initiatives that touch upon the duties of the authorities, a reality that made it possible for Ontario to escape the level of disarray found in Alberta. However, as with Alberta, the ministry too often intruded into operations of the LHINs (Ball 2015) and effectively fitted the regional authorities with a "very tight leash" (Eliasoph 2014, 66). Uncertainty and the lack of clarity also became evident in relations between the ministry and the LHINs. In her assessment of the LHINs, the auditor general of Ontario uncovered confusion over the funding of services (Office of the Auditor General of Ontario 2015, 351-52). Some of the LHINs expressed to the auditor their belief that the ministry could nullify any decisions of the LHINs that reallocated funds from one type of service to another. This understanding hampered attempts at the integration of services, for the successful connecting of services often required shifting monies to weaker points in the delivery of health services. The ministry countered that the belief had no basis in law, but nevertheless agreements between the ministry and the LHINs were adjusted to clarify the provisions on reallocations – an appreciable development but one that most likely came too late for the LHINs (Office of the Auditor General of Ontario 2017).

In summary, the relationship between the health ministry and the LHINs was characterized by uncertainty and a seeming reluctance by the health department to allow the LHINs the autonomy outlined in the accountability agreement. Even if uncertainties were

addressed at times, it seemed to be the case that any proposed initiatives or suggestions for major decisions would either emanate from the ministry or lead to its intervention. In a way, (as was the case in Alberta) this accountability problem, where the agency responsible for assigning responsibilities remained unwilling to grant the necessary autonomy, proved to be an impediment to the operation of the LHINs.

Physicians and Primary Care

None of the health authorities that have arisen in the past three decades in Canada, including those in Alberta and Ontario, have had responsibility for primary care physicians. This is the case even though doctors have an important impact on the operation of health authorities. For example, primary care represents a significant component of any attempt by authorities to integrate health services, yet an impressive portion of such services are under the control of physicians who organize and deliver care. This absence of accountability follows from a long-standing bargain between government and physicians where the medical profession agrees to accept government as the sole payer of physician services while government recognizes the role of doctors in determining the mode of payment and the organization of physician practices (Tuohy 1999). The agreement also applies to the ministries of health, but at least they can shape some aspects of physician behavior through their role as funder of medical services (Peckham, Ho and Marchildon 2018). The fact that ministries have resisted transferring this responsibility to the authorities shows that the absence of any control of physicians through authority arrangements is not solely the result of the bargain.

During the past decade, both the LHINs and AHS attempted to address primary care without having any direct responsibility for physicians. They pursued this end on their own by inviting doctors to participate in the planning and provision of primary care arrangements without any pretense of possessing authority to do so. A more effective way for engaging doctors, though, was to work through the health ministry, a body with some control of physicians. In the past decade and a half, primary care in Alberta was largely delivered through a new series of primary care networks (PCNs) that included doctors and other health professionals – a significant advancement, at least on paper. The PCNs, which were funded by the health ministry, worked in conjunction with AHS and evolved to service 70% of the population. The arrangements also sought to establish a system of “shared responsibility,” an intent that precipitated both doctors and AHS together drafting three-year business plans to be forwarded to the health ministry (Church, Skrypnek, and Smith, 2018, 49). But the absence of any formal understanding about expectations and goals between physicians and AHS within the PCNs and elsewhere precluded achievement of higher quality care and an integrated health care system (Office of the Auditor General of Alberta 2017). In 2017, a new PCN governance framework was established to support the integration of AHS programs and physician services (Church, Skrypnek, and Smith 2018). An important feature of this development was the forming of committees in each of the provincial health areas that permitted AHS and PCNs leaders to combine their efforts towards developing new initiatives and to fortify relations between the two bodies and heighten a sense of accountability for the new programs. (A province-wide version of the committees has also been set up to report directly to the minister on issues concerning primary care.)

Another development in Alberta worthy of note is that primary care physicians have assumed a role in an initiative which brings together various types of health care givers to address problems mostly in specific areas of care (Alberta Medical Association 2020). The initiative, which is called 'Strategic Clinical Networks,' relies on the teams acting with the support of AHS to create the networks necessary for effective treatment of designated ailments. Established in 2012, SCNs represents a type of accountability which emerges from giving greater responsibility and autonomy to care-givers, and there are indications that this approach is generating positive outcomes (Yiu, Belanger, and Todd 2019; Church and Smith 2021).

In Ontario, there were also important advances in the area of primary care. The health ministry encouraged primary care doctors to accept new methods of payment and delivery of services for the purpose of increasing the access and quality of health care. The traditional fee-for-service solo or group practices thus gave way in large part to a variety of new arrangements. One involved a group of doctors remunerated on a capitation basis and who provided care to rostered patients during and after normal working hours. Another relied on salaried nurse practitioners working with a team of health care providers and collaborating with physicians. These developments, though, took place before the advent of the LHINs, and when introduced the regional authorities were only given responsibility for Community Health Centers (CHCs). The CHCs, which relied on inter-professional health teams, provided care to communities without easy access to health services and represented a very small portion of total primary care services. But the many criticisms relating to the failure of the Ontario ministry of health to grant the LHINs more or even full responsibility for primary care led, in 2016, to notable changes affecting primary care. Amendments to the legislation governing the LHINs gave the regional authority responsibility to two additional types of primary care delivery. One was the nurse practitioners' arrangement, and the other was a form that consisted of inter-professional groups of health providers led by physicians. The nurse practitioner clinics, like the CHCs, constituted a small part of the area of primary care; the other new responsibility, called Family Health Teams, represented about one-quarter of patients enrolled in primary care arrangements (Rudoler et al. 2019). Equally important, the amended legislation also provided the LHINs with "an expanded mandate to include primary care planning," which suggested authority over *all* primary care arrangements in the province (Marchildon and Hutchinson 2016). However, the fact that responsibility for payment of physicians remained with the health ministry argued for a less expansive reading of the 'expanded mandate,' one that preserved the autonomy of doctors and their traditional role in medicine.

Adjustments in the delivery of primary care services in Ontario extended to changes that sought to encourage greater accountability by bringing care closer to communities. The amended legislation provided for five new sub-regions within each of the LHINs. The aim behind this action was in part to better recognize the health-care needs of residents. It was also hoped that the LHINs and its new sub-regions would as well serve to "work with local health system leaders, including family doctors, nurse practitioners, home care coordinators, and home and community care service providers ..." (Ontario Ministry of Health and Long Term Care, 2016). In other words, a process of self-organization and accountability among local health care providers might emerge spontaneously, a notion comparable to the operations in Alberta involving doctors. Similar thinking also supported the introduction of Health Links in Ontario, an initiative also relied on the almost spontaneous coming together

of providers to address the problem of high users of health care in specified parts of the province (Grudniewicz et al., 2018). Interestingly, an advisory body to the Ontario ministry of health recommended, in 2015, the setting up of bodies comparable to the sub-regions and the Health Links – with the authority as well to allocate funding to physicians (Price et al., 2015). The government rejected the proposal and maintained its control over the funding of physician services. The very consideration of the proposal, however, suggested that greater accountability in the delivery of primary care services might have been entertained.

Accountability in Alberta and Ontario

AHS and the LHINs had similar experiences with the two issues involving accountability. Both struggled with the absence of formal accountability arrangements with primary care physicians, even with concerted efforts to make doctors a more formal part of their operations. It is tempting to say that Ontario achieved greater success with primary-care doctors through initiatives that sought to almost lure doctors into accountability arrangements that relied upon self-organization rather than edicts from above. But the arrangements in Alberta for PCNs and SCNs also appear suggestive of a comparable advance. The two agencies also had to suffer accountability agreements that lacked clarity and legislation that received little recognition. Both relied on external forces to bring attention and in some cases a response to this problem of roles and responsibilities. All in all, then, the LHINs seemed at a minimum equal to AHS in confronting concerns about accountability.

Conclusion

This paper has offered a comparison of health authority arrangements in Ontario and Alberta. The purpose behind this comparison was to help decide whether the recent decision in Ontario to introduce a new arrangement for health care was a good one. If the Alberta system of a single authority turned out to be superior in the comparison, then the Ontario decision would appear to be acting wisely because the province has elected to follow Alberta's lead in embracing the single authority approach. If the most recent Ontario system of regional authorities prevailed in the comparison, it might be concluded that the new Ontario government should have stayed with the regional approach and put its efforts into exploiting the full potential of this way of regionalization. A safe conclusion emerging from the comparison suggests that little differentiates the two approaches. A more aggressive conclusion admits to the similarities in many of the measured outcomes, but that when differences did appear some key ones – ALC and timely access to care – tended to support the regional approach. In either case, safe or otherwise, the analysis points towards the conclusion that the Ontario government might have been too eager in its desire to provide Ontarians with a new way of organizing their health care services.

Notes

1. The paper assumes that the performance of the LHINs or AHS in the last ten years would, if adopted, represent a sufficiently accurate picture of health care in present-day Ontario. This is a safe assumption with the LHINs given that these regional authorities operated in roughly the same environment as the new government of Ontario. The assumption may be perceived to be on shakier grounds when applied to AHS. The use of a single authority arrangement for health care in Alberta might not produce the same result in

Ontario because of social and economic differences between the two provinces. This reality will be kept in mind when looking at the performance of the two arrangements.

2. To make the list of the AHS and LHINs expenditures roughly comparable, it was necessary to remove several items from the AHS list of expenditures. For the fiscal year 2009/10, the excluded items were ambulance services, promotion services, research and education, information technology, support services, amortization of facilities and improvements, capital assets write downs, and funded transition costs. For the fiscal year 2017/18, the items were population and public health, ambulance services, education and research, support services, and information technology. The adjustment resulted in both AHS and LHINs expenditures representing roughly one-half of total Ministry of Health expenditures, suggesting that the adjustment has some validity (unadjusted AHS expenditures constituted two-thirds of total ministry expenditures).
3. Population figures and inflation rates (government current expenditure implicit price) are taken from Canadian Institute for Health Information, *National Health Expenditure Trends, 1975 to 2018: Data Tables – Appendices A to D*. Canadian Institute for Health Information, *National Health Expenditure Trends, 1975 to 2021: Data Tables* available at *National Health Expenditure Trends, 2021 Data Tables*.
4. The period ends with the fiscal year 2016/17 and not 2017/18 (as is the case with AHS). Changes in the reporting of expenditures on community-based services in the 2017/18 fiscal year makes it difficult to ensure comparability with expenditures in preceding fiscal years. The adjustments repeat those outlined in the first note. Items were removed from the AHS list of expenditures which were not found in the list of LHINs expenditures. Without this adjustment, the increase in the share of funding to community-based services could be distorted by items not found in the LHINs budgets.
5. Adjustments are discussed in Note 2.

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