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Good afternoon and thank you for welcoming me at the end of what has been a very full day for all of you.

And my thanks to Gabe [Sekaly, CEO of IPAC] for inviting me to speak on the "road ahead".

I enjoyed reading the paper: How Can Local Healthcare Governance Survive? Let me start by saying that I agree with the paper's premise that local healthcare governance will survive. In fact I would go further and say it will flourish.

But for that to happen, we, as a health care system, need to modify our culture, our leadership and our accountability strategies.

As we all know transition takes time and is not easy.

For that reason, I am heartened to learn from the survey that an overwhelming number of you expect significant changes in the near future and that the majority believe there is capacity.

It is the purpose of conferences such as this to facilitate these changes.

So as I looked at the paper, I felt that it was important for me to share some of my perspectives that are beginning to reshape the Ministry of Health and Long Term Care for the future.

To clarify the direction that the Ministry is pursuing as we approach the questions of transformation, health system organization and governance.

For there are a couple of zingers, on pages 10 and 19 of the paper that cry out for comment.

I quote:

“If the LHINs emerged after the election as the ‘Performance and Compliance Police’, then our health-care services delivery organizations would simply shift their existing dysfunctional relations with the Health Ministry to the new LHIN Office.”

And:

“The Ministry may construct the same old command and control accountability architecture between the ministry and the LHINs so that the LHINs are forced to become the system manager – contrary the the model that the government has articulated.”

Well, thank you.

One could write this off as simply cynicism, but with a few minutes reflection, and recognizing the knowledge and experience of the authors, the statements are probably a reasonable apprehension of the Ministry.

So I want to give you my views on the Ministry and how it is changing, because it is important for the transformation that we all arrive at an understanding of where the Ministry is moving and what it will do and what it will not do.

Reliance on the Ministry to respond in the “old” way is moving to the past.

I am going to tell you today what I have said to the Ministry and what we are in the process of actively implementing.

We have branded this reforming of the Ministry under the title Stewardship.

And while the word has general connotations, it bears some explanation, not just from a theoretical perspective but also to describe the Ministry’s concrete behaviour and role in the system.

But first the context for the change:

The primary motivation has been this government's decision to transform the health system.

Now, as you know, of all the changes taking place in the health system, the most significant has been the government's initiative to place much of the operational decision-making in local hands through the introduction of the Local Health Integration Networks (LHINs).

On the first of April last year, Ontario's 14 LHINs officially assumed their statutory role. And as of last June, all of the LHINs had signed accountability agreements with the government.

Now the LHINs are responsible for the planning, integration and funding of the majority of health-care provider organizations in the province.

While the Ministry has retained provincial programs, some $18.9 billion of this year's $37.9-billion health budget is now administered by the LHINs.

Today the hospitals, long-term-care homes, community services, mental health agencies, and CCACs report directly to the LHINs.

And with the LHINs in place, we are beginning the implementation of health-care decisions being made by the health needs of people and their communities.

And the government's decision to create LHINs, as well as other factors, has demanded that the Ministry of Health and Long Term Care re-evaluate its role and function in the system.
Stewardship means driving strategy and performance, making wise use of our resources, making the health system accountable for outcomes and – ultimately -- making the health system more sustainable.

To be stewards, the government, the Ministry, health organizations and providers, must move to the characteristics and behaviours that are outlined in the paper under the 2nd Curve description.

The system as a whole must respond in this way if we are to be successful in the future.

And so the key characteristics of patient focused, alignment, seamless referral, collaboration, joint accountability for outcomes, common purpose and so forth are not just words, but attitudes, behaviours, and actions that must be put into practise.

But more importantly, the Ministry must develop the culture for fulfilling those principles.

This means changing the relationships inside the Ministry, and hence the organizational and business process changes that are well underway.

And at the same time, developing whole new ways of approaching our partners, our providers and our public.

In the Ministry, the concept of stewardship calls on us:

- to guide and direct the health system through strategy development, planning, and evaluating;
- to set those directions and enable the choices that others will make to improve the health system;
- to ensure that the system is driven by the needs of citizens of this province; and
- to partner with the broad range of health-care providers.

That's a seismic change for the way in which Ontario's health system operates.

And, while this has been led with vision and strategy, the implementation will now require a huge change for all us in the Ministry: a change in behavior; in who we talk to, in what we talk about, and in how we spend time in the workday.

As I mentioned, LHINs now administer about $20 billion -- more than half the current $35-billion health budget.

The scale of this shift provides a reference point for the actual scale of change we're talking about.

If more than half of the Ministry's premise and strategy regarding funding has changed, by implication at least half of what we do every day logically needs to change as well.

This is perhaps a litmus test for us to think about. Half of what the Ministry does is changing.

Does that mean that our priorities, procedures and processes are changed by 50 per cent?

Does it mean our culture must change as dramatically as 50 per cent?

Right now this is a work in progress, but these questions give us reference points for the Ministry's progress and commitment.

The shift to the LHINs will relieve the Ministry of a lot of the day-to-day work of managing the health system. And that means that the Ministry is now in a position to support and guide the health system.

It means that we will move away from program management and towards health-service delivery strategy: strategy that will in turn guide the LHINs and their communities.

We're now shifting away from day-to-day micro- management to overall strategic planning.

Most importantly, we're now beginning to remove the policy barriers and controls that have previously inhibited seamless access to health care and the integration of health-care services.

Stewardship is a very different type of leadership. Rather than managing towards an objective, stewards also manage towards an obligation to the future.

Our purpose becomes much greater than what we need to accomplish today.

Managing with an obligation to the future will be central to all our work. This is the public trust at the core of our stewardship. And that's a long-term responsibility, one that represents a major shift from program management to planning from the patient's perspective and the perspective of the health of populations.

Those are the principal elements of the Ministry's business that we're gradually working towards, and for which we're building the supporting organizational structure.

Now the Ministry has always practiced elements of stewardship, but too often that's had to compete with the day-to-day operations of health-system management.

We've spent an awful lot of time on the details of the here and now, and not enough on where we're going tomorrow.

The concept of Stewardship hinges on another important factor, and that is the notion of trust.

We need as a Ministry to appreciate the quality and innovation that we've already achieved and that's at work across the system. With this confidence we can get out of people's way and leave them to do what they do best.

We make our contribution by letting people across the health system know what's expected of them; and by setting the parameters in which we expect them to practice their professionalism, innovation and accountability.

The assurance that the health system can deliver quality services competently comes from the two-way trust we've built between the Ministry and the health system.

That frees the Ministry to focus on the priorities of patient-centered care and a health system that's sustainable.

To achieve those goals, the Ministry will spend more time and resources in understanding our direction and determining our benchmarks.

Where we can, we need to change our business processes to those that answer the critical questions about the future of health care in Ontario.

We will need to ask ourselves how we get from where we are today to where we want to be in three, five, ten years down the road…and at what level of performance.

We need to identify the barriers to accomplishing our goals and make changes to our policies, practices and procedures that no longer work.

But the Ministry also needs to:

- remember and honour the principles that got the health system to where it's at today;
- be innovative and intelligent when it comes to meeting current needs; and
- to ensure that this asset will be sustainable and flexible enough to enrich the lives of future Ontarians.

So let's turn to the central question of the paper: Can local governance survive?

Well of course it has to survive if the changes in the system we need are to be achieved.

The model of organization and operation that the government has chosen relies on effective and responsible governance both from LHINs and health organizations.

But in the same ways that the Ministry must change, so too, must local governance change.

Our former model put too much credence in the ability of the Ministry to manage the system from on high, and not enough authority in the hands of local health providers to organize and deliver service that was in the best interests of patients.

And so with, delegated authority to communities through LHINs, it is now the responsibility of local governance bodies to step forward and jointly claim the ground that has been given.

The vision of our new model is not simply delegating to LHINs to replace the old Ministry, but to create a process of engagement so that there can be common purpose, coordinated service delivery, adjusting services to need and creating a real system.

But this cannot happen without commitment and without partnership.

And so partnership is a key element of the concept of stewardship.

And I think it important to talk about what partnership means. I use Peter Block as the reference here.

Partnership has defining elements:

<u>Common purpose</u>

- established through dialogue
- full participation

<u>Joint accountability</u>

- we are each responsible for the success of the whole
- the price of freedom is shared responsibility

<u>The right to say "no"</u>

- open voices
- striving for the best
- not always win, but no loss of voice

<u>Absolute honesty</u>

- fundamental to concept

<u>No abdication of responsibility</u>

- silent watching with arms folded and jaws clenched is abdication

These ideas are all part of what I include in the concept of stewardship, and there are strong overlaps in the 2nd curve notions.

So again as I look at the paper, there is for me a strong sense of being on the same page.

To that end, I endorse the paper's check points for the "system" and I believe that every organization, including the Ministry, should consider these points, which I've taken the liberty of amending to reflect the Ministry's perspective.

<u>One</u>: clear roles and responsibilities of all stakeholders, including the Ministry, are crucial

<u>Two</u>: the focus has to be on the needs of the public, not on advocacy for an institution or specific constituency

Three: there needs to be a common vision for the system shared by all stakeholders, including institutions and their employees

Four: accountability processes need to be clear, outcome focused, publicly reported, and they need to link the organization's employees to the system's accountability architecture

Five: all employees, not just the CEO and Executive Director, must be held accountable for outcomes

Six: innovation and customer-service must be the primary consideration for all stakeholders

Seven, and perhaps, most important: we cannot continue to tolerate a fragmented, silo-based, unaligned, bureaucratic system.

And if we all, regardless of the positions or roles we play in the system, operate according to these principles, then the system will evolve and change to meet the objectives for improvement in the health care system.

We must as a health system, engage this together.

The government has set out the general outlines. It is now our joint responsibility to move forward, to engage in the process, and focus on how together we can realize better performance, better service, better outcomes and better quality for the public, which we all serve.

I believe that we are on the right path. It is my fervent hope that the leaders in the health system and most importantly, local governors, share this commitment and will move forward, in partnership, to realize the benefits to which we all aspire.

And at this conference four years down the road, I believe the authors of a similar paper will affirm that the Ministry and the health-system stakeholders have developed effective partnerships to best serve the public.

Thank you for your kind attention.