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Contemporary Corporate Theory Applied to the Health Care Sector: A Canadian Perspective

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I. INTRODUCTION

This article briefly considers the intersection between corporate governance and the delivery of health care services. It suggests that while effective governance is critical to the oversight and delivery of health care, the very nature of health care service is that it provides essential services to citizens. Hence, efficiency, which is classically one attribute of effective governance, must be defined differently if the oversight of health care delivery is to meet its public policy goals of timely and accessible health care. Although the focus of this article is Canada's health care system, which is largely not-for-profit, there are comparative lessons that can be drawn for governance in the health care market in the United States.

Generally, corporate governance is the structure and processes by which corporate decisions are made so that capital is raised in a cost-effective manner, assets are utilized to efficiently generate wealth, and corporate directors and officers are accountable to those investing in the firm in a manner that controls agency costs.[2] In the health care context, the governance of health care institutions such as hospitals, nursing homes, medical laboratories, diagnostic centers and clinics, includes government funding, insurance plans, investment strategies, and raising capital in a cost-effective manner through fees for services. In addition, assets must also be used effectively. Efficiency considerations include not only the cost-benefit analysis of a particular decision, but also contain an important element of service delivery. Effective governance means the timely delivery of the

health care products or services, while having regard for resource limits, as well as accessibility and universality goals. When services are delivered privately, there are different kinds of pressures. Private sector health providers in Canada and the United States face both service pressures and profit-maximizing pressures in their governance decisions.

Effective governance oversight requires development and implementation of strategic planning, oversight of the decision making and risk assessment processes, and supervision of corporate officers to prevent shirking or self-dealing transactions. Contemporary corporate governance theory suggests that there are a number of principles for good corporate governance. These principles include the effective stewardship of the enterprise, the independence of corporate directors, effective audit reviews, and the enhanced disclosure of corporate transactions to shareholders and other stakeholders. In the health care context, effective governance encompasses the consideration of both public and private interests in the effective management and delivery of health care services, with the public interest continuing to be the principal consideration.

In Canada, there is a lack of scholarship regarding governance in the health care marketplace. As a result, this article is meant to provide an introduction to the topic of governance and a means to generate discussion. It raises issues and questions, as opposed to providing a comprehensive analysis. Part II sets the framework for the discussion by examining the structure of health care delivery in Canada and its socio-economic context. Part III provides a brief introduction to the growing debate in Canada as to whether health care services should be delivered exclusively by public service deliverers, or whether there is a role for private for-profit corporations. Funding limits may drive decision makers towards greater privatization; however, there are numerous concerns, including how international trade policies may affect long-term health care delivery and policy choices.

Part IV examines the intersection of corporate and health care governance, and suggests several policy objectives that should be considered in analyzing effective governance in the health care sector. Part V explores the governance challenges particular to the health care sector, including system sustainability, oversight, and infectious disease crisis management. This article suggests that instruments that may be used in the health care marketplace to ensure effective governance include competent stewardship and accountability to a broader constituency, enhanced disclosure, implementation and monitoring of privacy policies, and decision-making processes that deal with the specific challenge of ethical decisions in a market context.

II. THE CANADIAN HEALTH SERVICES CONTEXT

Canada's delivery of medical and health care services differs substantially in its capital structure from the delivery given in the United States. In contrast to the largely privately capitalized U.S. system, Canada's health care delivery is still, for the most part, publicly funded.[3] The governing legislation, the Canada Health Act (CHA), has long had the objective of providing universal access to health care.[4] Health care services are primarily paid through tax dollars.[5] Thus, while health care is not "free" because Canadians support the system financially, all individuals receive necessary medical and health care services without having to pay fees for service at the time of delivery. Given that most of Canada's health care is provided on a not-for-profit basis, the issues of governance, accountability, and ethics in health care oversight differ in Canada from the private for-profit sector considerations faced by the U.S. health care market.

A few points regarding the structure of Canadian health care illustrate the differences between the Canadian and United States regimes that have implications for governance in the health care sector. Canadian health care is a national system that is delivered locally and is based on inter-governmental policy and funding. Constitutionally, both federal and

provincial governments have jurisdiction over aspects of health care delivery in Canada even though the primary responsibility rests with the provinces.[6] The CHA sets out the framework for health care in Canada as well as the funding structure. It enshrines basic principles of Canadian Medicare, specifically, public administration, universality, accessibility, portability, and comprehensiveness. In 2002, CHA services amounted to $44 billion or 42.4 percent of the total public and private health care expenditures.[7] 71 percent of the total funding for Canadian health care comes from taxation.[8] Provincial per capita health care spending rose 16 percent in the past decade.[9] Regional health authorities, which are funded by general tax revenues, allocate resources to coordinate and try to improve services aimed at promoting and protecting health. They also work towards the prevention of disease and injury.[10] The vast majority of Canadian hospitals are nonprofit institutions and, in most provinces, are operated by regional health authorities.

Additionally, the CHA effectively bans patient-user fees on hospital and physician services.[11] Physicians are primarily sole or group practitioners with service arrangements at hospitals, who are paid on a fee for service basis by provincial government health insurance plans. Hence, individuals that access physician services at hospitals or at physician offices, rarely, if ever, pay fees for those services. There are also community health clinics in which doctors are salaried, which are similar to some HMOs in the United States, except that they are funded by public tax dollars instead of group insurance or other private contributions.[12] Canada has also developed a strong paramedic and public health workforce, with a range of professionals engaged in preventive and palliative care. More than one million and a half Canadians work in health care and social services supporting health care.[13]

For many years, the private sector played virtually no role in health care delivery in Canada; however, this has changed in the past two and a half decades. Private sector health services that exist now are directly paid for by individuals or are covered through private insurance or employee benefit

plans. The private sector now delivers $33 billion in services, which comprises 32.4 percent of Canada's total health care expenditures.[14] Large, for-profit businesses are confined primarily to laboratory and diagnostic services and long-term health care facilities.[15] Home care services cost $2.7 billion annually; nursing homes and other chronic care facilities cost $6.8 billion annually; and $800 million is spent on non-physician professional health services each year.[16] Under the CHA and companion provincial legislation, private companies are prohibited from selling insurance contracts for medically necessary physician and hospital services; however, they can sell health insurance for uninsured health services beyond the scope of provincial health insurance plans.[17] Individuals receive tax deductions if their uninsured medical expenses are greater than 3 percent of their income, consisting of deductions worth an estimated $4 billion per year.[18]

A national Commission on the Future of Health Care in Canada, the Romanow Report, recently analyzed the challenges and opportunities for health care delivery and access in Canada.[19] The Romanow Report discussed how Canada could ensure the long-term sustainability of a universally accessible, publicly-funded health care system.[20] Although the report focuses on the consumer side of the issues, some of its findings set the context for discussing governance and health care. The Romanow Report found that Canadians continue to desire a truly national health care system; want a more comprehensive and accountable health care system; and generally believe that equal and timely access to medically necessary health care services is a right of citizenship.[21] The Report's extensive study revealed that Canadian Medicare has consistently delivered affordable, timely, accessible, and quality health care and that, with a few exceptions, Canada's health outcomes are among the best in the world.[22] Yet, the Report found that there are monumental changes occurring in Canada's health care delivery system. These include changes to traditional medical models, the growth of multidisciplinary approaches to health

prevention and treatment, the growth in drug therapy, and the increasing capital costs for diagnostic and treatment equipment. The rapid changes have created new risks for governance oversight of the sector, including a new awareness by Canadians of the risks to universality that are inherent in rapidly rising costs and pressures to privatize services.

III. THE PUBLIC/PRIVATE DEBATE

A key debate in Canada is the extent to which the current public system should allow for private delivery of services. The delivery of primary health care in Canada is still largely a not-for-profit enterprise, even though for-profit corporations have long been active in the nursing home and home for the aged sectors, in diagnostic and laboratory services, and, increasingly, in providing support services to hospitals. While a comprehensive analysis is beyond the scope of this brief paper, it is important to note that the pressure to consider divesting particular health services has become a critical debate in the future of health care delivery.

The implications of the public/private debate for governance are evident. Current boards of directors or health councils charged with overseeing nonprofit service delivery are responsible for ensuring that health care managers utilize resources with a view toward efficient and effective service delivery. Additionally, while fiscal accountability is important, the pressure of making a profit does not currently drive oversight, dictate actual governance decisions, or set measures of performance. Further shifts to private sector delivery of the public system would generate a host of new pressures on these directors and officers that would likely detract from the universal goals of Canada's Medicare system.

Given Canada's longstanding commitment to publicly delivered health services, the introduction of private service providers in any aspect of health care delivery was controversial, particularly in the late 1970s and early 1980s when U.S. corporations sought to enter the Canadian market. Scholars, health care providers, and hospital directors were concerned that

the price of economies of scale and efficiency would sacrifice the quality of care for those who must access the health care system. This private/public debate recently reappeared as hospital boards and other oversight bodies grappled with burgeoning health care costs. Given the resources available, particularly in the long-term and chronic care areas of delivery, in which the private sector has already made inroads in the market, there is continuing debate regarding whether private sector service delivery is of the highest possible quality. One example is the decision of directors and officers to distribute resources away from long-time loyal caregivers in long-term care facilities to less expensive labor that has been contracted without the same continuity of care. This has squarely raised the question of how profit considerations can drive service delivery decisions. There is also concern that the corporations already delivering chronic and long-term care in Canada will shift into primary health care and, consequently, will risk eroding some of the best features of Medicare.

A particularly controversial issue is the move by some provinces to public-private partnerships, referred to as "P3s." P3s are a relatively recent phenomenon, arising in part from limited capital funds to build medical and health care facilities. There are different types of P3s, including the privatization of public assets, the contracting out of services, and the financing, building, and operating of new facilities under long-term leases. Several Canadian studies that have advocated for a greater move toward public private partnerships suggest that this practice has long been established in the United States. These partnerships are being considered for hospital construction, service delivery, records management, and diagnostic services.[23] However, the Romanow Report observed that these partnerships often cost more in the long term and contested the quality of their service delivery on a for-profit basis.[24] Despite this report, several provinces are proceeding with construction of hospitals on a P3 basis with only limited public policy input into the decision. Essentially, the governance issue arising from these developments is whether P3s are an

effective model of delivery of public services when governance is divested to private for-profit decision makers.

The current privatization initiatives are also driven by strong normative perceptions that when resources are limited, for-profit managers are more effective at raising capital and delivering services. Equally, there is a perception that public decision makers are not as accountable in their management activities because they do not have to be concerned with the "bottom line" in the same way as private for-profit firms. However, these perceptions are not supported by empirical evidence. There are numerous instances of financial distress, mismanagement, and bankruptcy of for-profit health care providers, just as there are instances of financial and operational success. Moreover, the publicly governed health sector frequently has strong governance.

Not-for-profit hospitals and other boards are often comprised of business and community leaders who contribute not only effective oversight and financial skills, but have put in place comprehensive governance structures for strategic planning, risk management, and service delivery. Hence, for-profit corporations are not necessarily more efficient; efficiency depends on the governance structure in place, including accountability to investors and oversight of managers' operational decisions. The measure of effective governance is obscured when discussed as only involving private/public capacity to be efficient. Effective governance structures and practices, in either sector, underlie the quality of delivery of health care services. Therefore, broad generalizations about the ability to manage mask a much deeper normative debate regarding the role of the government in the delivery of services. All other factors equal, public delivery is preferable because any excess dollars generated are efficiencies reinvested in the health care delivery system, as opposed to being siphoned off, in the form of dividends or interest payments, to meet the demands by private investors for return on their capital.

Endorsing public delivery of health care as an effective governance model for Canada does not suggest, however, that not-for-profit delivery is unencumbered by the pressures that the private sector faces. For example, in some provinces, hospital funding is based on cost management. Funding is adjusted for relative efficiency performance and measured on the basis of cost per weighted case over all inpatient and day surgery activities, compared against the expected cost per weighted case.[25] Hospitals that are more efficient on this basis receive more funding, creating a risk of competition for increased patient volumes to the detriment of quality and effective governance. While there is no doubt that competition is a prerequisite for continued economic growth, such strategies may cast the paradigm of the desired outcome too narrowly in terms of the continued development of effective health care delivery.

Public funding of health care is not without its governance challenges, particularly in the structure of transfers of federal and provincial funds to local and regional service delivery organizations. The recent shift to global funding from the old line-by-line health and medical care services approval streamlined the administrative costs associated with determining transfer fund amounts, reducing transaction costs in the determination of health care funding allocation. While this shift has reduced oversight costs in the central funding of health care, it raises the issue of fairness and a lack of transparency in the allocation of resources and determination of which decisions maximize health outcomes. This change has moved the locus of accountability for distributive decision-making from the relatively public arena of governmental budget approval to the relatively less public deliberations of hospital boards and management committees. Hence, the governance challenge is how the boards and committees can be held accountable for their distributive decisions.

As noted earlier, effective governance includes mechanisms for transparency and accountability to those with an interest or investment in the organization. In response to these changes, there must be a mechanism

in place to ensure that hospital directors and other health care managers are engaging in decision making aimed at meeting the public policy goals of Canada's Medicare system.

Canada has a mixed market economy with a very developed corporate sector and healthy capital market. Hence the notion that health care is better delivered by the public system differs from the perception that other economic activity is best generated by private sector activity. This normative choice of delivery model is a result of the longstanding principles of the CHA. Yet, there are pressures for change. The business lobby to alter the system has become very active, particularly from U.S. based companies entering the Canadian market. The Romanow Commission faced calls from business interests for a greater shift towards providing private health care services that included user fees, medical savings accounts, de-listing of Medicare-covered services, greater privatization, and a parallel private health care delivery system.[26] The Commission sought evidence on how these proposals would improve the delivery of health care services and concluded that the evidence was not forthcoming.[27]

Instead, it found overwhelming evidence that user fees, even at relatively low levels, impede access to necessary health care for the poor.[28] Although the Report expressed concern about the recent growth in private services, private capital is increasingly part of the Canadian public health care system. For example, private magnetic resonance imaging (MRI) clinics allow those with resources to have preference in the public system for treatment over those waiting for publicly-financed MRI services as a condition precedent to treatment decisions.[29] The Report advocated that the government draw a clear line between direct health care services such as hospital and medical care that should continue to be governed as public services, and other services such as food preparation and maintenance, which increasingly are delivered through private enterprises.[30] Thus, at the heart of the debate about the public/private divide is a strong normative

commitment by Canadians to retain the universality and accessibility of health care service delivery.

A. The Challenge of Trade Treaties

Another key aspect of the health care governance debate is the impact of trade treaties on the integrity of the Canadian system. As a function of Canada's limited bargaining power, Canada has not faired well in international trade agreements with the United States. Now, the concern is that treaties will be used to dismantle current protections that maintain the integrity of the health care system. A recent study by the Canadian Centre for Policy Alternatives examined how P3 financing could negatively impact Canada based on its trade and investment treaty obligations.[31] The study found a risk to the Canadian Medicare system due to trade and investment liberalization. The Centre observed that if P3s become entrenched in Canada, foreign health care insurers and companies could make use of the North American Free Trade Agreement's (NAFTA) expropriation-compensation rules to remove current protection for Canada's Medicare system.[32]

Under NAFTA, Canada originally negotiated exemptions for the health sector that allowed the Canadian government to maintain all non-conforming provincial government measures, including most health care delivery. Any shift away from nonprofit to for-profit health care may be irreversible because existing services under Canadian Medicare are protected, but not necessarily new initiatives, including a shift to for-profit services.[33] The study also found that ongoing negotiations to expand the General Agreement on Trade in Services (GATS) are placing considerable pressure on the Canadian government for new restrictions on domestic regulation that protect Canada's Medicare system.[34] Under GATS, any reductions in public health insurance coverage that governments could opt for today would be difficult for governments to reverse in the future.[35]

Given the importance of the Canadian Medicare system, steps should be taken to protect the system against potential challenges under international trade treaties.[36] This is a governance issue because local governments and health care providers may undertake decision making based on short-term financial pressures without appreciating that they may be exposing both their own organization and the health system more generally to treaty litigation. In turn, this could lead to higher costs for comparable or lower service delivery, creating a downward spiral of funding and services that those with oversight would have difficulty stemming.

Trade treaty risks need to be factored into governance decisions, yet there is currently a lack of transparency and accountability in terms of how, if at all, this is done. The current policy setting in health care is structured such that the governance decisions being made at the local level do not properly take into account the broader public policy implications. Governance decisions such as the universality of insurance for particular services, P3 projects, and financing of services, must be strategically planned to maximize the use of existing protections under NAFTA and GATS.[37] In order to accomplish this, local and regional health care decision makers need to consider the broader public policy implications of local delivery decisions and, in turn, undertake their planning processes to assure that Canadian citizens have input, and to require the local decision makers to have some degree of accountability. In this way, Canada may be able to preserve and extend universal access to services and prevent erosion of the quality of health care delivery.

B. Rhetoric and Reality

The above mentioned issues illustrate the corporate governance challenges in the health care marketplace. Canadian health care providers are struggling with the growing costs of health care delivery and the challenges of sustainability. Given that provinces control most of the primary health care delivery, there are also growing tensions between

provinces that have adopted a slash and burn type of system and those that struggle to maintain the universality of the system. For the casual observer, the true extent of the challenge is masked. For example, in the past two years in British Columbia, media accounts are replete with protesting health care workers and consumers regarding wholesale reduction of health care funding and services. Yet the 2003–04 Service Plan of the Ministry of Health discusses reforms that are patient-centered, accessible, and high quality, which result in improved health and wellness and are sustainable and affordable over the long term.[38] On paper, the goals appear to align with good health care governance, but the recent cutbacks suggest that more transparency regarding the changes and empirical studies are necessary before one can assess the direction of health care in that province. This is echoed across Canada and was part of the genesis of the Romanow Report on the future of national health care.[39]

In 2004, the public/private divide in health care delivery will be tested before the Supreme Court of Canada in *Chaoulli* v. *Attorney General of Québec*.[40] The Court will consider the constitutionality of provisions in health insurance legislation that prohibit private health care insurance for services covered under Québec's health insurance plan. Similar prohibitions are reflected in provincial legislation across Canada.[41] Canadians can travel outside of the province or the country and can pay for medical services or seek services on a fee-for-service basis at private clinics. The issues are whether Canadians should be able to purchase insurance to cover such costs, whether such insurance would create a two-tiered health care system, and what the appropriate balance of public and private access to health care should be.

The Canadian health care context, and particularly the public/private divide issues, provides the backdrop for thinking about health care governance. While P3s and other recent pressures to move to for-profit enterprises have not fully taken hold in Canada, they serve as sources of

normative and financial pressure on decision makers as they make governance decisions in the delivery of public services.

IV. THE INTERSECTION OF CORPORATE AND HEALTH CARE GOVERNANCE

A benchmark of effective corporate governance is the quality of the corporate board's oversight of the activities of the corporation and its officers and agents. Governance generally raises questions about whether investors are adequately protected, the effectiveness of strategic planning processes, how efficiency is measured, and who participates in the risk/benefit decisions that form the basis of corporate transactions. However, in the health care marketplace, governance entails developing strategic planning for the health care institution or enterprise, the oversight of the activities of health care managers or officers, the consideration of whether multiple users or stakeholders are adequately protected in their receipt of medical or health services or in their investments, and the participation in risk assessment processes including consideration of the ethical issues that arise in the context of the delivery of a vital public service. By necessity, health care governance is a highly dynamic regime with rapid changes driven by an aging population, an aging health care workforce, increasingly complex and expensive technology in diagnostic and treatment tools, increased costs of pharmaceuticals, and changing morbidity and mortality patterns.

Disclosure is a key feature of corporate governance. Transparency of business plans and operational results allow corporations to attract and retain capital and allow investors to monitor the use of their equity or debt capital. Applied to the health care sector, the types of corporate objectives that might be disclosed include policies relating to medical and service delivery ethics, funding priorities in terms of capital projects or service delivery, and environmental and other public policy commitments. Such disclosure allows the health care institution to be evaluated in relation to its

delivery mandate and community needs. The disclosure problem squarely raises the issue of the extent to which health care officers and managers should be accountable to investors, including consumers of the health care services and citizens through the collective engagement of their tax dollars.

In order for disclosure to be an effective tool of governance, it must have a means by which it can create incentives to change. In the for-profit sector, incentives are generated by the ability of shareholders to exit by selling their shares in the market when the disclosure reveals problems, or to use the threat of exit to influence corporate behavior. However, in the not-for-profit publicly-funded sector, the connection between disclosure and incentive to improve is less clear. What mechanism can be used to hold decision makers accountable for their governance decisions if the group to whom they are accountable has no effective means of voicing its views on the oversight decisions? While regional health councils do perform aspects of this role in Canada, as do governments as proxies of taxpayers, those most directly invested in, and in receipt of, health care services do not have access to accountability structures. In determining how to create a voice for health consumers/investors in the governance decisions of hospital and other public boards, it might be helpful to refer to recent legislative initiatives that have provided minority shareholders in corporations with a greater voice.

The challenge for accountability is even greater with the growing diversity of capital structures in health care and the increased amount of private health care delivery. Generally, in the corporate arena there has been rigorous debate on the necessity and scope of regulatory intervention in governance. I have suggested that this has shaped the debate regarding protection of equity capital as a fundamental principle to the exclusion of consideration of other kinds of investments, with distributional consequences for social and economic wealth.[42] With the shifts to private delivery of services, many of these challenges are now entering health care governance. The Canadian health care system has traditionally been

accountable to public consumers through the periodic mechanism of elections where, as taxpayers, consumers voice their approval or disapproval of governance choices. However, this is too blunt a tool because it only measures overall satisfaction with health care governance. It does not allow for accountability checks for directors and officers of particular health care institutions or agencies. Shifts from public to private governance shift not only the normative objectives (for-profit versus not-for-profit), but also the mechanisms to influence policy on delivery of health services.

Similarly, a challenge for governance of both private health care enterprises and public health care institutions is to ensure that the health care system has the capacity to meet anticipated demands for health services. This includes, human resource planning to ensure the supply, retention, and effective deployment of health care professionals and support workers. Health care activity substantially contributes to the Canadian economy in production/service output and employment in direct and spin-off businesses. For example, in 1997, the health research economic base in the life science industry was $36 billion, and in 2003 the life science industry employed 130,000 researchers.[43] Hence, governance must take into account health care services as an economic investment tool, with the attendant need to effectively direct economic, service, and research activities.

Whether the delivery of health care is public or private, it is necessary to develop a governance framework that clearly defines policy objectives and responds to primary health care needs. These objectives include prevention, early detection, patient-centered treatment, effective quality health care delivery (including geographically accessible health care to meet current shortages in rural, northern, and First Nations communities), a more comprehensive definition of accessible heath care that addresses the needs of those with mental illness and those who require palliative care and post-acute home care, and a legislative framework that includes public coverage

for medically necessary diagnostic services including the finances to support this delivery in a timely and effective way.[44]

To prevent shirking or self-dealing by decision makers, the framework requires enhanced disclosure to consumers, including information about their own health status and the potential health outcomes of any particular treatment. Strategic human resource planning for the supply and distribution of health care workers is also a necessary component of governance if providers are to respond to rapidly changing health care needs. Training and education will allow health care providers to work in integrated team settings, responding to the changing skill sets required in the health care sector while still recognizing prior contributions of these professionals. Finally, the governance framework must foster transparency and accountability in decisions regarding ethical standards, health care delivery, and funding.

In meeting these objectives, there may be different policy priorities across the public and private sectors. Ideally, in publicly delivered health care, those with stewardship of public resources should be accountable to the public. Costs should be measured against the public's perception of whether the goals of accessibility and universality are achieved. However, in the private sector, even when the goal is timely and effective service, there is considerable pressure to maximize profits. While these issues are frequently at odds with one another, they intersect at the need for effective governance.

V. THE HEALTH CARE MARKETPLACE—OVERSIGHT CHALLENGES AND INSTRUMENTS OF EFFECTIVE GOVERNANCE

In the current health care marketplace, sustainability is a key challenge, both for the long-term viability of a particular organization and for the overall long-term protection of timely and accessible health care services. Sustainability can be accomplished by effective oversight and stewardship, by ensuring that decision makers act independently to assess strategic and

operational choices, by establishing mechanisms to respond to crises that are unique to health care, and by promoting ethical practices by all market participants. These are discussed in turn.

A. Sustainability and Oversight

Health care enterprises and governments at all levels are struggling with how to improve the quality of health care delivery and management of services under the pressure of burgeoning costs. In order for Canadian health care delivery to be sustainable, there may be a need to re-conceptualize health care financing and management. National health standards need to be reinforced with enhanced measurement and disclosure of performance. Performance is normatively defined by enhanced health outcomes or by increased control of costs. How one measures performance leads to particular choices in governance. A series of government policy documents being produced in Canada examine sustainability goals and ways to measure achievement of the goals. One Alberta study has proposed three screens for measuring the optimal mix of publicly-funded health care services: a technical screen that assesses whether treatments are safe and demonstrate positive health outcomes; a social and economic screen that assesses ethical issues and access to health care services; and a fiscal screen that assesses the cost implications of funding particular combinations of services.[45]

The policy objectives enshrined in these recent studies, which promote a shift in governance goals, are laudable, but they are accompanied by particular challenges for health care sustainability. For example, the objective of providing the best care possible in an appropriate setting calls for the optimal mix of hospital, acute care facilities, and home and community care services. An integrated health care delivery system is a sensible governance objective. In their oversight obligations, directors may determine that reducing the length of hospital stays is efficient in terms of resources expended within the institution. To prevent unnecessary

hospitalization, however, health care consumers must have access to better support in the community such as physicians, nurses, service providers, and home care services so that they receive the required continuum of care and support. But once patients are released into the community, hospital and acute care facilities have limited control over delivery choices. The risk posed is that access to acute care services is reduced and patients are returned to the community too rapidly for the available support services. As a result, community health care services are stretched inappropriately, and family members bear an increasingly heavier share of post-acute, rehabilitative, and palliative care, resulting in economic and social costs to the family.[46] In sum, these issues are complex and difficult to resolve.

Policy objectives aimed at providing alternatives to institutional care must ensure that health care resources are seriously directed to alternatives and must ensure that effective governance mechanisms are in place for adequate oversight and delivery of community-based alternatives. Hence, a challenge for governance is to ensure that hospitals and similar institutions do not minimize their costs by creating what are referred to as "externalities" in corporate governance theory. Externalities are created when the organization sheds costs outside of the organization to give the appearance of generating efficiencies while merely transferring those costs to other parts of the system without clear evidence of the public policy benefits of such actions. These governance decisions have distributive consequences for health consumers in terms of both the availability of services and the financial burden that it may create.

Similarly, the governance objective of managing within budget allocation assumes that adequate funds will be allocated for health care spending. There are difficult ethical and moral questions about who should have priority in accessing acute care services, and there are serious risks posed by making allocation decisions based on age, health, and economic status. Should those with financial oversight of the health care enterprise be

determining these priorities? Should the decision making also involve health care practitioners, consumers, and health care advocates?

Governance should ensure that the health care delivery organizations are accountable to the communities in which they operate. This accountability should be grounded in public policies of investor (taxpayer and consumer) protection, environmental protection, and employment standards.[47] Professor Lynne Dallas has suggested that a corporate board representing diverse interests is a means of enhancing governance, including assisting in acquiring resources, reducing environmental uncertainty, making optimal use of the skills of diverse participants, and ensuring that decision making takes account of the context in which the corporation operates.[48] Extending this to the health care sector, boards of health care institutions could engage in more effective oversight by ensuring that diverse interests are represented at the governance level through diligent recruitment, selection, and the training of directors. The board could insist on similar processes throughout the organization that make assessments of where resources will be allocated. Further, it is worth remembering that public health care institutions face capital constraints unlike those in the private sector because they cannot seek additional capital in the market. Constraint may make the most effective oversight unable to generate more positive health income.

Effective strategic planning has its greatest positive measure in improved health outcomes, as opposed to profits that are generated. For example, the objectives of prevention of disease, illness, and injury are vitally important goals of the health care system. Health promotion, disease prevention, and injury prevention programs encourage healthier living, address risks to health, and prevent future health problems.[49] Yet, even the link between prevention and a positive health outcome requires careful oversight of decision making. Many preventive programs are currently aimed at lifestyle choices regarding the consumption of goods and the increase of physical exercise. While these are vitally important factors in morbidity

and mortality, there are larger health related issues that cause serious health harms.

For example, environmental conditions, lack of enforcement of workplace health and safety standards, and economic conditions that lead to widespread poverty and inequitable access to positive health outcomes are all health related issues that cause serious health harms. However, health care institutions and their governance practices are only one piece of the sustainability puzzle, and even the most effective oversight of these institutions alone will not result in sustainability. Just as for-profit corporations are faced with the challenge of competition in the global capital marketplace, those with oversight obligations of publicly delivered services need to engage in sustainability planning on both a micro and macro level.

Issues of employment, environmental, and occupational health and safety conditions present significant challenges that pose serious barriers to increased prevention and health promotion. For instance, the failure to take expeditious regulatory action regarding asbestos, smoking, and toxic substances used in workplace processes has direct implications for health care management and costs to the system. Currently, the corporate enterprises that generate these problems do not pay for the health care costs associated with the inevitable, negative health outcomes caused by their wealth-generating activity.[50] As a result, there are inadequate incentives to reduce harm, and the cost of the harm is shifted to the already overburdened health care sector. As long as the costs of these harms are externalized from the corporations to the tax base and health consumers, there will be few *ex ante* incentives to reduce environmental and occupational harms. One further issue is whether it is the responsibility of those with oversight of health care enterprises to raise these issues, as key advocates in health care delivery systems and governmental relations.

For publicly-funded, nonprofit health organizations, the issue is whether the current accountability mechanisms are able to generate the appropriate

proactive response to issues of sustainability. Without the need to generate profits and the budget setting power of the private sector for-profit organizations, how can the nonprofit institution receive the signals that highlight the need to look at sustainability? On the other hand, sustainability is always counterpoised to the continuous pressure to generate profit in the for-profit sector. Thus, in the for-profit sector, the issue will be how and by what mechanism an appropriate balance can be struck between profit and the sustainability of the health care system.

B. Stewardship and Accountability

Stewardship and accountability are two critical components of effective governance. Stewardship refers to the duties of directors and officers to be diligent and responsible in their decision making and oversight, and by which they have regard for the objectives of the health care institution for which they are responsible. In corporate law, one thinks of stewardship as the oversight of the operation to ensure that corporate officers maximize enterprise value. Accountability refers to the obligation of directors and officers to be answerable for their decisions and the mechanisms that exist to make this accountability meaningful by creating incentives for change when effective oversight or management is lacking.

Governance of health care institutions is arguably more nuanced and more challenging. Both corporations and health care institutions should seek to enhance their ability to raise capital, achieve environmental and production sustainability, and to effectively comply with legal standards. However, the health care sector has the added challenge of providing timely and accessible services. In both Canada and the United States, health care enterprises operate in a highly regulated environment. Compliance with legal and professional standards is a key governance objective because failure to comply may adversely affect licensing or funding to continue operations. Interestingly, public governance of health care delivery is administratively more efficient than in the private for-profit sector. As a

result of Medicare's single payer system, the Romanow Report revealed that Canadians pay two-thirds less than Americans for health care administration on a per capita basis.[51]

Effective stewardship responsibilities include setting the strategic direction of the health care enterprise and monitoring the progress of the ongoing implementation of the strategic plan; evaluating both the upside and downside risks of particular strategies and creating formal systems for identifying and assessing risk; and approving and monitoring major capital expenditures, capitalization decisions, acquisitions, divestment and funding. Stewardship involves the recruiting, appointing, setting the compensation for and monitoring performance of senior managers. It entails monitoring the operational and financial performance of the health care enterprise and regularly assessing that performance against the strategic plan. It must also involve the monitoring of compliance with statutory and regulatory requirements, which include ensuring that mechanisms are in place to identify, report, warn, and then remedy any failure or risk of failure to meet standards. Effective oversight also requires having an audit committee in place that reviews the enterprise's financial statements, reviews reports of external and internal audits, and has an effective process for responding to and correcting problems or challenges raised by the audits.

In Canada, many of these stewardship measures are being implemented by health care institutions as benchmarks of effective governance. Yet, not all governance decisions can be effectively managed by the individual institution. For example, accessibility has been a hallmark of the health care system; yet, there are problems becoming apparent in the system, indicating a need for enhanced stewardship in service delivery decisions. The University Health Network reported that in 2001, hospitals in Toronto, the second largest city in Canada, were on critical care by-pass (not accepting ambulances) for 30 percent of the time in the month of May.[52] Furthermore, the wait time for elective MRI tests was six to eight weeks; and 30 percent of cancer patients were waiting longer than the

recommended maximum eight weeks for radiation therapy.[53] There have also been periods of net migration of physicians and nurses out of Canada, which necessitated the importation of professionals from developing countries; as a result, the pool of physician and nursing services in those nations is depleted.[54] Many of these issues involve stewardship beyond the individual health care enterprise, which implicate the government's stewardship responsibilities.

Directors owe a fiduciary obligation to act in the best interests of the corporation or the health care enterprise. This necessitates careful and prudent management of resources, having regard to those with interests in the health care enterprise. In the Canadian system, there are different stewardship incentives depending on where the decision maker is located. Hospital managers are required to procure and deliver services as efficiently as possible. Such efficiency is measured by the costs of providing particular services in the hospital. Directors, officers, and managers are responsible for ensuring compliance with legal and professional standards; managing technologies, including appropriate adoption, financing and monitoring of health outcomes; developing strategic plans for targeted acquisitions of specialized technology based on population needs and possible collaborative use of these technologies with other facilities; and developing programs that assess clinical benefits and cost-effectiveness of technologies. In contrast, physicians have professional standards that relate to both competence in their field and standards of ethical practice. Many of the clinical decisions are made by the physicians; thus, direction on the amount of nursing or physiotherapy care, the levels of medication, diagnosis, and treatment are driven by a care ethic in which physicians work in tandem with, but independently of, decisions of hospital administrators.

Health care is now a $100 billion enterprise in Canada. While the overwhelming majority of these expenditures are under the control of governments or their agencies, issues of accountability and oversight are key challenges.[55] Accountability in the health care sector requires more

than accountability to shareholders. It requires careful decision making on where to expend resources in a world of increasingly complex health problems and greater demands for new technological intervention. It also requires difficult decisions about where to allocate dollars in the health care system so that it meets the needs of society and is still an economically viable enterprise.

The Romanow Report characterized Canadians as the shareholders of the public health care system because they own it and are the sole reason that the health care system exists.[56] Canadians feel a sense of entitlement to universally accessible health care. This issue was apparent in the 2004 federal election where Canadians identified universal access to publicly-funded health care as one of the most important issues facing Canada.[57] In response, the Canadian prime minister in September 2004, announced $41 billion of new federal funding over the next ten years to support the government's action plan on health.[58] The funding will be aimed at fulfilling the recommendations of the Romanow Report and will allocate resources to reduce acute care wait times to northern and Aboriginal communities and to home care services and catastrophic drug coverage.[59] This priority expressed at the polls resulted in new funding and planning commitments by the federal government. However, accountability also requires mechanisms that allow Canadians to express health care preferences between elections. This would enhance the regulatory and institutional accountability that is already well developed in the Canadian health care system.

Another aspect of accountability is the issue of negligence and medical malpractice. In Canada, long-established standards of care are being challenged by the impact of funding cutbacks, service reallocation, and the implications for doctors and others making decisions on medical and health care. Limited resources, particularly in emergency rooms, may give rise to new concerns regarding reasonable care standards and the risk of liability.[60] Physicians owe duties to both the hospital in which they are working and to

the health care consumers they are treating. Physicians are at risk of making health care decisions based more on resource restrictions than best treatment practices, which in turn may give rise to new liability concerns and may have negative effects on health care services. Unlike the United States, where medical malpractice has long been a feature of the health care system, in Canada malpractice has not generally been an issue. Hence, the incentive effects of funding constraints on health care directors, officers, and direct service providers require further consideration.

Accountability also engages the debate regarding how health care providers can be accountable to shareholders for their decisions. Creating diverse representation on health care boards provides one measure of expanding accountability. However, given the fundamental nature of health care delivery, a question for future research is whether there is a framework that allows health care enterprises to effectively manage their resources while providing a role for public policy, regulatory standards, and the participation of health care consumers in governance decisions that affect health care delivery in the community.

C. Independence of Directors

Perhaps the greatest lesson of the recent corporate scandals in the United States is the need for independent oversight by a board of directors. Health care governance also needs effective independent oversight. The board's role is to monitor the effectiveness of the overall operations of the health care enterprise in order to ensure the long term value and sustainability discussed above. Director independence requires the ability to dispassionately assess whether or not officers are implementing the enterprise's strategic plan, are effectively operating the business, and are not engaged in self-dealing or shirking. As demonstrated by the Enron scandal, it is apparent that even when the majority of directors meet statutory definitions of independence, there is still the need for independent oversight

to reduce opportunities for self-dealing, self-enrichment, and corporate culture that fail to engage in effective oversight.

The successful achievement of independent oversight varies in Canadian health care institutions. In publicly run Canadian hospitals, board members are drawn from both the health care profession and the public; boards frequently seek to attract independent people with diverse skills to act in an oversight capacity. For private hospitals and health care institutions, there is a particular challenge to ensuring independence, especially when board members are selected by corporate officers or are nominated by major shareholders.

In the United States, publicly traded health care corporations must now comply with new regulatory standards under the NYSE or securities legislation and must ensure that the majority of directors are independent.[61] In Canada, while this is considered to be best practice by the Toronto Stock Exchange, to date, corporate law does not require that the majority of directors be independent. However, these policies are shifting for companies that are public issuers as new national securities instruments are imposing independence requirements similar to those in place in the United States. In both jurisdictions there are obligations to ensure that directors disclose economic and other relations with health care corporations, and there are statutory provisions designed to prevent self-dealing by directors. Independence requirements are also starting to drive recruitment, selection, and retention of directors and officers in not-for-profit health care institutions as auditor generals increasingly monitor governance activities in their assessment of fund transfers to these agencies.

Independence must be accompanied by other factors necessary for effective oversight. Directors of health care institutions should contribute knowledge, experience, skills, expertise, and diversity that will allow the board of directors as a whole to oversee and to direct the business and affairs of the enterprise. These diverse skill requirements apply whether the enterprise is publicly or privately held. However, independent oversight

does not equate with inaction, and directors have a positive obligation to monitor and take action to ensure the health care enterprise is meeting statutory and regulatory standards.

The duty to monitor requires the following: access to financial and operating information; access to managers to answer questions and to provide information; time provided to effectively scrutinize proposed changes to capitalization, operations, or strategic direction; the ability to access independent advisors when necessary; succession planning for key directors and officers; and separate sessions of non-management directors on a regularly scheduled basis so that directors can reflect independently on the overall management of the health care enterprise. These are elements of good governance that should be considered in ensuring that directors are independent, diligent, and acting in the best interests of the health care enterprise.

In addition to annual independence checks, health care boards of directors are increasingly undertaking performance reviews, in terms of evaluating their effectiveness in the oversight process, of both the board of directors as a whole and of individual directors.[62] Performance reviews consist of self-evaluation, evaluation by other directors, and evaluation by those immediately working with the directors (a "360 evaluation"). Such evaluation can identify areas in which directors may require enhanced training, such as in audit functions, and it can also identify weaknesses in the range of skills covered by the board, which in turn provides valuable information for recruiting new directors to the board.

Finally, in monitoring the operational and financial performance of the health care enterprise, there is an obligation for directors to independently assess whether or not the enterprise is operating ethically, responsibly, and in compliance with legal, regulatory, and professional standards. As will be discussed below, ethical decision making is particularly significant in the health care sector.

D. Transparency, Disclosure, and Privacy Challenges for Governance

Generally, corporate governance disclosure is viewed as essential to capital markets. Investors need to be able to access information that will allow them to determine whether to invest their capital in a particular enterprise or whether to exit. Optimal disclosure involves not only profit and loss disclosure, but also disclosure in terms of the activities of the corporation, sustainability measures, as well as mechanisms in place for the avoidance of conflicts of interest and managerial shirking. Recent Canadian securities regulation also includes requirements for issuers to report environmental, social, and health risks to the enterprise as part of transparency initiatives.[63] In the health care marketplace, calls for enhanced disclosure are aimed at increasing the accountability of decision makers and at providing a reliable base of information from which to make difficult decisions about the allocation of increasingly scarce health care capital. Essential information management and technology systems are required, including the ability to manage, monitor, and make transparent the costs and benefits of new technology and treatment strategies, as well as to monitor threats to public health. The recent Severe Acute Respiratory Syndrome (SARS) crisis highlighted the need for transparency and disclosure between institutions, health care authorities, and nations in order to alert health care deliverers and the public to potential risks. A measure of good governance is effective information management with transparency in both health risks and in the decision making processes.

There are also critical issues associated with patient rights to disclosure about their own health information. Recent health information legislation authorizes individuals to access their own health information and establishes rules regulating the registration, collection, disclosure, and protection of health information by custodians.[64] The Centre for Global e-Health Innovation has observed that consumers want to participate in health related decisions, want full access to information, want the right to disclose that information to another provider and seek a second opinion, and want to

communicate with their health care providers.[65] The Canada Health Infoway is a government supported nonprofit corporation with responsibility for accelerating the development and adoption of modern systems of information technology, with the aim of providing enhanced health care.[66]

The Romanow Report emphasized that a critical component of enhanced disclosure is the need to expand health literacy by creating access to relevant, credible, and user-friendly health care information. Another crucial component of enhanced disclosure is facilitating development of skills for health care consumers to process and understand the information.[67] In light of these developments, the role of the board is to ensure that managers are responding to these challenges and initiatives in a manner that complies with regulatory requirements and respects privacy concerns.

The other side of the disclosure issue is the privacy interest. With the introduction of personal electronic health records and electronic medical summaries providing key patient information to authorized primary health care providers, there is a need to ensure limited access, protection of privacy, and sanctions for violation of that privacy. In Canada, privacy legislation in the health care sector has been aimed at both facilitating the sharing of health information among professionals in order to enhance diagnosis and treatment, and the challenge of ensuring that an individual's health information remains private.[68] Increased technology has meant increasing challenges for health information custody and oversight of that activity. Privacy considerations enter into decisions regarding resource allocation to establish and maintain information-sharing systems with the appropriate privacy safeguards. Hence, oversight of budget and financial decisions requires strategic planning and resource allocation to meet the privacy challenges and appropriate controls on information flow.

These privacy issues also engage the public/private debate with respect to how information services are effectively delivered while protecting privacy

interests. In April 2004, the British Columbia Government and Service Employees' Union petitioned the Supreme Court of British Columbia to declare that the contracting out of information services to a private company in the United States was in violation of the CHA and the Medicare Protection Act, constituting a violation of the Freedom of Information and Protection of Privacy Act.[69] The British Columbia Ministry of Health Services sought a private partner to take over the operation of the B.C. Medical Services Plan, including medical records management and processing.[70] The proposed private partner is a U.S. firm subject to the U.S. Patriot Act ("Patriot Act").[71] The accompanying affidavit by a lawyer with the American Civil Liberties Union suggests that there is a serious threat to the privacy of medical records under section 215 of the Patriot Act, given the extraordinary powers granted to the FBI to secure and retain such records without any mechanism through which a person served with an order to disclose can challenge the order before complying with it.[72] The petitioner alleges that the Patriot Act could be used to secure the records of Canadians if a Section 215 Order is served upon the company, even if the records are held in Canada.[73] The petitioner urges the B.C. privacy commissioner to examine the implications of information services being outsourced to a United States linked service provider and to determine whether it is a violation of the CHA.[74] This B.C. initiative has also sparked a Right to Privacy Campaign by consumer health and rights groups because of their concern that medical and health records obtained under the Patriot Act would be used for inappropriate purposes in violation of Canadian Charter rights.[75]

While technology has enhanced access to information for consumers and for the profession such that better and timelier care decisions can be made, it has also created new concerns for ensuring that sensitive health information is secure. Effective governance requires that these systems are monitored, periodically evaluated, and adjusted in order to meet privacy concerns.

E. Infectious Disease Crisis Management

Health care oversight is further complicated by shifts in patterns of disease. A key governance challenge is how to provide effective mechanisms to deal with the outbreak of quasi-epidemics of new infectious diseases. An example is the recent crisis generated by the outbreak in Canada of SARS. Any belief that North America had infectious diseases under control was shaken in 2003 when the City of Toronto faced a public health crisis in SARS cases, including forty-four deaths of patients and health care providers and a billion dollars in economic damage to the community.[76] The SARS outbreak highlighted the need for the health care system to immediately respond to protect consumers, professionals, and the public. Health care institutions were among the key actors that had to make decisions regarding the treatment of those affected by SARS, the need to protect health care workers, the closure of hospital services to new patients, the quarantine of thousands of individuals, and the prohibitions on patient visitors and non-essential workers.

Numerous governance questions arise out of the SARS crisis that have not yet been resolved, either domestically or internationally, in jurisdictions that have recognized this vulnerable aspect of their oversight obligations. The questions include the following: how can health care facilities best manage a crisis with available resources, and are there systems in place for identifying and immediately responding to suspected infectious disease outbreaks? What is the standard of care expected from health care institutions, and how can hospitals put in place mechanisms that respond to service needs while providing liability protection for emergency response professionals? What are the rights of employees exposed to infectious diseases who refuse to work, and how may they be compensated if they are unable to perform their work safely?[77] What is the liability risk for health care institutions and governments if they fail to adequately warn the public

and ensure adequate testing? Is there a need to rethink insurance and contract clauses to address the question of *force majeure* clauses for risk allocation?[78]

Other important questions are how one addresses the issue of voluntary or mandatory quarantine for those exposed to highly infectious diseases, and how one enforces a mandatory system. While most people complied with the quarantines during the SARS crisis, some did not. Both provincial and federal governments have amended health protection legislation to increase quarantine powers in such circumstances, cognizant of the possible challenge posed by balancing public health protection and risk of Charter violations of an individual's liberty rights.[79] At the same time, the crisis engaged privacy concerns because the government refused to name those with SARS.[80] This raises the question of whether the existing rules of confidentiality should change during an infectious disease crisis, and if so, how the privacy of individuals can be protected while simultaneously monitoring threats to the public's health. These are both health and governance questions that must be explored in the near future.

F. Ethical Decision Making in the Health Market Context

Governance of health care requires ethical decision making in all aspects of the oversight obligation—from decisions on capital projects to service delivery. The need for ethical behavior in the health care context is essential because decision makers are often dealing with vulnerable stakeholders. Health care directors and officers have an obligation not to exploit that vulnerability and to fulfill their fiduciary obligations by acting with due care and diligence. Ethical decision making is best approached by creating an ethical climate that permeates the board of directors and all levels of the organization.

In her paper entitled *Enron and Ethical Corporate Climates*, Lynne Dallas examines the institutional structures that give rise to particular corporate ethical climates.[81] She suggests that organizational policies,

practices, and procedures influence moral awareness, moral behavior, and the criteria used in moral decision making, and that these factors were influential in creating the climate for unethical behavior that led to recent corporate scandals in the United States.[82] Examining literature on moral and ethical behavior across several disciplines, Professor Dallas concludes that individuals ordinarily determine the appropriate course of action by reference to social norms in their working context; whether employees apply a different set of ethics at work and at home; whether empathy-based morals are encouraged or discouraged; and individual choice of referent (the person after whom their behavior is modeled).[83]

These observations have resonance for the health care sector. If the climate is one in which the profit motive is the primary driver, then the climate may discourage empathy-based care giving and decision making. If those with oversight of the health care enterprise set the tone or moral direction and are the referent for employees, then decisions about whether health care delivery should be focused primarily on the health care consumer or primarily on cost-containment will profoundly influence how decisions are made and carried out on the hospital, nursing home, or clinic.

These questions engage issues beyond compliance with legal standards of care and professionalism. Such standards, which are legislatively set in health laws and regulatory instruments and by self-regulating professions, carry sanctions for non-compliance. For the most part, in Canada, they are effective in maintaining high standards of care and professionalism. The availability of sanctions for unethical behavior acts as a normative temper on self-dealing or shirking. However, ethics engage a range of other decisions that may affect consumers' experience with the health care system. Ethics decisions may affect consumers' ability to make informed choices about health decisions and treatments, may relate to the quality of care they receive, and affect the value assigned to providing a positive experience by health care providers at all levels of a health care organization.

Compliance with legal standards and requirements should ideally only be the base requirement with health care delivery organizations offering a level of care, service, and accountability that exceeds statutory minimum requirements. The board's role is to ensure that their managers' decision making is meeting these objectives. It is here that ethics plays a role. In health care, there are thousands of decisions made daily on the basis of treatment needs, consideration for the physical, mental and emotional health of the consumer, and limitations in resources and personnel. If one considers health care a public good, as it is in Canada, then the decision makers must pay attention not only to profit margin and cost control, but also to the delivery of effective, accessible, transparent, fair, and ethical health care. The institutional ethical climate set by those with oversight and governance responsibilities will determine much of the conduct in the frontline delivery of services.

Health care enterprises that are adopting codes of ethical conduct are attempting to ensure a level of practice and procedures aimed at ethical standards and delivery of service. Underpinning such codes is the expectation that directors, managers, and staff will have objectives of integrity, honesty, and fairness in their dealings with health care consumers. A key factor in the effectiveness of such codes is that employees receive adequate information and training on the expectations under such codes. Hence, health care directors should have monitoring systems in place to ensure that the actual practices meet these standards. There should be mechanisms that allow for both health care consumers and employees to report violations of ethical codes of conduct, without fear of reprisal either in the quality of their health care or in their employment status. The codes must be enforced in order to set standards of delivery that truly meet the health care delivery objectives of the organization. There must also be mechanisms to periodically review the standards and codes of conduct based on society's understanding of what constitutes effective governance. In addition, the health care enterprise may have learned lessons from a

particular experience or case of health care shirking that requires the ability to adjust the institution's standards of care and conduct.

VI. CONCLUSION

While the purpose of corporate activity generally is to maximize the value of the enterprise, the goal of health care governance in Canada is to maximize the value of its health care services. In this, Canada does not face quite the same governance challenges as the health care market in the United States, where the simultaneous, and sometimes conflicting, goals of profit and service delivery are particularly challenging. However, the need for effective corporate governance, with its goals of enhanced disclosure, oversight, and accountability, is as great in Canada's publicly-funded, not-for-profit system as it is in a for-profit corporate enterprise.

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[2] Janis Sarra, *Oversight, Hindsight and Foresight: Canadian Corporate Governance Through the Lens of Global Capital Markets*, *in* CORPORATE GOVERNANCE IN GLOBAL CAPITAL MARKETS 42 (Janis Sarra ed., 2003). *See* Gustavo Visentini, *Compatibility and Competition between European and American Corporate Governance: Which Model of Capitalism?*, 23 BROOK. J. INT'L L. 833 (1998); Fabrizio Barca, *Alternative Models of Control: Efficiency, Accessibility and Market Failures*, *in* PROPERTY RELATIONS, INCENTIVES AND WELFARE 194, 195 (John E. Roemer ed., 1997).

[3] Health Canada–Online, Health Care, *at* http://www.hc-sc.gc.ca/english/care/ (last visited Nov. 14, 2004).

[4] Canada Health Act, R.S.C. 1985, ch. C–6 (1985) (Can.).

[5] COMMISSION ON THE FUTURE OF HEALTH CARE IN CANADA, BUILDING ON VALUES: THE FUTURE OF HEALTH CARE IN CANADA–FINAL REPORT 24 (Roy J. Romanow, Q.C., 2003) (also issued in French under the title, *Guidé par nos valeurs: l'avenir des soins de santé au Canadai*)
http://www.hc-sc.gc.ca/english/pdf/care/romanow_e.pdf (last visited Nov. 14, 2004) [hereinafter Romanow Report].

[6] *See* Schneider v. The Queen, [1982] 2 S.C.R. 112, P60. The federal government has responsibility for regulation of prescription drugs and public health promotion, the provinces are responsible for primary health care delivery, although these services are cost shared through a federal transfer system. *See id*. at P59.

[7] Romanow Report, *supra* note 5, at 4.

[8] *Id.* at 24. In the United States, private insurance is a significant way of funding health care, supported by tax expenditure subsidies. When these tax breaks are accounted for, it is estimated that just under 60 percent of total health care spending in the U.S. receives public support, what scholars have called "public money, private control." *See id.* at 27.
[9] *See id.* at 34.
[10] *See*, *e.g.*, Regional Health Authorities Act, R.S.A., ch. R–10, § 5 (2000) (Can.).
[11] Romanow Report, *supra* note 5, at 28.
[12] *See id.* at 6.
[13] Statistics Canada, Employment, Health Care and Social Assistance: Provinces and Territories, *at* http://www.statcan.ca/english/Pgdb/health22.htm (last visited Nov. 14, 2004).
[14] *Id.* at 5 (these figures for the 2001–2002 fiscal year include dental service expenditures).
[15] *See id.* at 6. The Romanow Report reported that the extent of direct health care service by private companies was unknown but that one study estimated 300 private-for-profit clinics in Canada, delivering a range of services such as abortions, endoscopies, physiotherapy and laser eye surgeries. *Id.*
[16] *See id.* at 34.
[17] *See*, *e.g.*, Health Insurance Act, R.S.Q., ch. A-29, § 15 (1977) (Can.), *available at* http://www.canlii.org/qc/laws/sta/a-29/20040901/whole.html (last updated Sept. 1, 2004).
[18] Romanow Report, *supra* note 5, at 5 (including tax credits for individual health costs and a policy of not taxing private health premiums paid by employers).
[19] *Id.*
[20] *Id.* at 1.
[21] *Id.* at xvi, xix.
[22] *See id.* at xxiii (it is important to note that the Romanow Report found that there continue to be serious disparities in access to health care and health outcomes in specific regions and populations in Canada, particularly for Aboriginal peoples and those living in the North).
[23] *See* Standing Senate Committee on Social Affairs, Science and Technology–Final Report, *The Health of Canadians–The Federal Role*, *Volume Six: Recommendations for Reform* (Oct. 2002) (Can.), *available at* http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/SOCI-E/rep-e/repoct02vol6-e.htm (last visited Nov. 5, 2004); Report of the Premier's Advisory Council on Health, *A Framework for Reform: A Diagnosis of Healthcare in Canada*, at 6–9 (Aug. 2000) (Can.), http://www.premiersadvisory.com/pdf/PACH_report_final.pdf (last visited Nov. 5, 2004).
[24] *See* Romanow Report, *supra* note 5, at 30.
[25] University Health Network (Toronto), Submission to the Standing Committee on Social Affairs, Science and Technology, Academic Health Science Centers Hospital Reform Issues 15 (May 22, 2002), *at* http://www.uhn.ca/uhn/corporate/community/docs/kirbysubmission.pdf. The University Health Network was founded in 1998 with the merger of three major Toronto hospitals; it employs 9,000 staff, with annual revenues of more than $800 million. University Health

Network, Presentation from University Health Network to the Commission on Future of Health Care in Canada 2 (Sept. 26, 2001), http://www.uhn.ca/uhn/corporate/community/docs/romanow_submission_final.pdf.

[26] *See* Romanow Report, *supra* note 5, at xx.

[27] *Id.*

[28] *Id.* at 28.

[29] *Id.* at xxi.

[30] *Id.* at xxi.

[31] *See* JIM GRIESHABER-OTTO & SCOTT SINCLAIR, BAD MEDICINE: TRADE TREATIES, PRIVATIZATION, AND HEALTH CARE REFORM IN CANADA (2004), *available at* http://www.policyalternatives.ca/publications/bad-medicine.pdf (last visited Nov. 5, 2004).

[32] *See id*. at 11.

[33] *Id*.

[34] *See id.* at 13.

[35] *Id.* at 105.

[36] Romanow Report, *supra* note 5, at 246.

[37] GRIESHABER-OTTO, *supra* note 31, at 149.

[38] British Columbia Ministry of Health Planning, *Service Plan 2003/04–2005/06*, at 3 (2003) (on file with author), *available at* http://www.bcbudget.gov.bc.ca/bgt2003/sp2003/hp/hp.pdf (last visited Nov. 11, 2004).

[39] *See also* Alberta Health and Wellness, *Achieving Accountability in Alberta's Health System* (Nov. 2001), *at* http://www.health.gov.ab.ca/resources/publications/pdf/Accountability_2001.pdf (last visited Nov. 5, 2004).

[40] Chaoulli v. Québec (Procureure Generale), [2002] 116 A.C.W.S. (3d) 266 (Que. C.A.), *leave to appeal to Supreme Court of Canada granted*, [2003] CarswellQue 850.

[41] *Id*. The challenge comes under provisions of the Canadian Charter of Rights and Freedoms, alleging violations of section 7, the right to life, liberty and security of the person; section 12, the right against cruel or unusual punishment or treatment; and the section 15 equality provisions. *See* Department of Justice-Canada, *Canadian Charter of Rights and Freedoms* (Constitution Act, 1982), *available at* http://laws.justice.gc.ca/en/charter/ (last visited Nov. 5, 2004).

[42] *See generally* Sarra, *supra* note 2 (discussing UNITED NATIONS DEVELOPMENT PROGRAMME, THE HUMAN DEVELOPMENT REPORT: CULTURAL LIBERTY IN TODAY'S DIVERSE WORLD (2004), *at* http://hdr.undp.org/reports/global/2004/ (last visited Nov. 5, 2004)).

[43] Romanow Report, *supra* note 5, at 86.

[44] *See id.* at xxiii–xxxiv.

[45] *See* Alberta Health and Wellness, Expert Advisory Panel to Review Publicly Funded Health Services, *The Burden of Proof: An Alberta Model for Assessing Publicly Funded Health Services*, at 9 (Mar. 2003), *available at* http://www.health.gov.ab.ca/about/reform/pdf/EAPprocess.pdf (last visited Nov. 5, 2004).

[46] The Canadian employment insurance plan is introducing, for the first time, an allowance for workers who must stay home to provide chronic health care support to family members.

[47] *See* Marleen A. O'Connor, *The Human Capital Era: Reconceptualizing Corporate Law to Facilitate Labor-Management Cooperation*, 78 CORNELL L. REV. 899, 958 (1993); Lawrence E. Mitchell, *Cooperation and Constraint in the Modern Corporation: An Inquiry into the Causes of Corporate Morality,* 73 TEX. L. REV. 477, 502 (1995); David Millon, *Communitarianism in Corporate Law: Foundations and Law Reform Strategies*, *in* PROGRESSIVE CORPORATE LAW 1 (Lawrence E. Mitchell ed., 1995).

[48] Lynne L. Dallas, Developments in U.S. Boards of Directors and the Multiple Roles of Corporate Boards, *in* CORPORATE GOVERNANCE IN GLOBAL CAPITAL MARKETS 191 (Janis Sarra ed., 2003); see also Lynne L. Dallas, *Two Models of Corporate Governance:* Beyond Berle and Means, 22 U. MICH. J.L. REFORM 19 (1988).

[49] Alberta Health and Wellness, *Ministry of Health and Wellness Business Plan 2003–06*, at 206 (Mar. 21, 2003), http://www.finance.gov.ab.ca/publications/budget/budget2003/health.pdf.

[50] However, the corporate enterprises do pay some limited costs under workers' compensation systems.

[51] Romanow Report, *supra* note 5, at 61.

[52] Commission on Future of Health Care in Canada, *supra* note 25, at 8.

[53] *Id.*

[54] Romanow Report, *supra* note 5, at 102 (in 2000, Canada experienced a net loss of 164 physicians to other countries).

[55] *See id.* at xix.

[56] *Id.*

[57] For one particular stance on this issue, see DAWN, Election 2004 Vote for Equality, Equality Rights Issues, *at* http://dawn.thot.net/election2004/issues.htm#22 (last visited Nov. 14, 2004).

[58] Health Canada–Online, Health Care Renewal, *New Federal Investments on Health Commitments on 10-Year Action Plan on Health*, Sept. 16, 2004, *at* http://www.hc-sc.gc.ca/english/hca2003/fmm/funding_bk.html (last updated Sept. 28, 2004).

[59] *See id.*

[60] For a discussion of this issue, see Frank McLaughlin, *Crisis in the Emergency Room? Physician's Liabilities in the Fact of Limited Resources in Canadian Emergency Rooms* (July 1, 2000), http://www.mccarthy.ca/pubs/publication.asp?pub_code=682.

[61] *See* PricewaterhouseCoopers*, Sarbanes-Oxley: Relevance and Implications of Certain Provisions for Non-Public Healthcare Organizations*, Jan. 2004, *at* http://www.healthcare.pwc.com/cgi-local/hcregister.cgi?link=pdf/sarbanes.pdf (last visited Nov. 14, 2004).

[62] *See* Sarra, *supra* note 2, at 57.

[63] *See* Robert Repetto et al., *Environmental Disclosure Requirements in the Securities Regulations and Financial Accounting Standards of Canada, Mexico, and the United States*, Mar. 25, 2002, at 13, http://www.cec.org/files/PDF/ECONOMY/env-disclosure-25-03-02_en.pdf (this was a report prepared for the Commission for Environmental

Cooperation for the meeting, *Finance and the Environment: Transparency, Disclosure, and Environmental Reporting*).

[64] *See*, *e.g.*, Health Information Act, R.S.A., ch. H-5 (2000) (Can.).

[65] Alejandro R. Jadad et al., *The Global e-Health Innovation Network–Building a Vehicle for the Transformation of the Health System in the Information Age*, *in* BUSINESS BRIEFING: NEXT GENERATION HEALTH CARE 48–54, http://www.ehealthinnovation.org/html/publications/eh_publications.shtml (last visited Nov. 11, 2004).

[66] Romanow Report*, supra* note 5, at 79–80.

[67] *See id.* at 81.

[68] Ministry of Health & Long-Term Care, *Personal Health Information Privacy Legislation for the Health Sector (Health Sector Privacy Rules)* (2001), *at* http://www.health.gov.on.ca/english/public/pub/ministry_reports/phipa/phipa_mn.html (last visited Nov. 5, 2004).

[69] *See* Petition of B.C. Gov't and Serv. Employees Union v. Minister of Health Servs., *in Petition to Supreme Court of British Columbia*, at 3, 4 (2004) (Can.), http://www.bcgeu.ca/bbpdf/040301_petition.pdf (last visited Nov. 5, 2004); Canada Health Act, R.S.C., ch. C-6, § 7 (1985) (Can.); Medicare Protection Act, R.S.B.C., ch. 286 (1996) (Can.); Freedom of Information and Protection of Privacy Act, R.S.B.C., ch. 165, §§ 30, 33, 79 (1996) (Can.).

[70] *See* Petition of B.C. Gov't, *supra* note 69, at 3–13.

[71] Pub. L. No. 107-56, 115 Stat. 272 (2001).

[72] *See* Office of the Information & Privacy Commissioner, Request for Submissions: Assessing U.S.A. PATRIOT Act Implications for Privacy Compliance under British Columbia's *Freedom of Information and Protection of Privacy Act*, at 2, 3, 10–12 (May 28, 2004), *at* http://www.oipcbc.org/news/21120publicinvite.pdf.

[73] *See* Petition of B.C. Gov't, *supra* note 69, at 13.

[74] *See id.* at 4.

[75] *See* Press Release, Right to Privacy Campaign, Right to Privacy Campaign Launched to Protect Individuals' Privacy by Stopping Maximus Deal (June 21, 2004), *at* http://www.righttoprivacycampaign.com/NewsRel/NewsReleases/RPC/NewsRelease%2004-06-21.pdf.

[76] *See* Michelle Mann, *Outbreak: Is the Law Ready for the Next Epidemic?* (Oct. 2003), *available at* http://www.cba.org/cba/national/oct03/PrintHtml.asp?DocId=53782 (last visited Nov. 5, 2004).

[77] *See*, *e.g.*, SARS Assistance and Recovery Strategy Act, S.O., ch. 1, §§ 6, 9 (2003) (Can.) This statute provided for emergency leave entitlement for employees that took a leave during the SARS outbreak and were unable to work because they were under individual medical investigation, supervision, or treatment related to SARS; were acting in accordance with a SARS related order; were in quarantine as a control measure; were under direction of the employer in response to a concern that the employee may expose others in the workplace to SARS; or because the employee was needed to provide care or assistance to an individual because of a SARS related matter. While the leave provided under this statute was unpaid, it did provide for the right of reinstatement and protected employees against reprisals for taking a leave related to SARS.

[78] *See* Mann, *supra* note 76.
[79] *See*, *e.g.*, Health Protection and Promotion Act, R.S.O., ch. H.7, § 22(4)(c) (1990) (Can.).
[80] *See* Mann, *supra* note 76.
[81] Lynne L. Dallas, *Enron and Ethical Corporate Climates*, *in* ENRON: CORPORATE FIASCOS AND THEIR IMPLICATIONS (Nancy B. Rapoport & Bala G. Dharan eds., 2004). Professor Dallas defines ethical climates as the ethical meaning attached by employees to organizational policies, practices and procedures. *Id.* at 187
[82] *See id.* at 188–192.
[83] *See id.* at 192–194.