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## Seeking Accountability: Multi-Service Accountability Agreements (MSAAs) in Ontario's Community Support Sector

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## Abstract

Multi-Service Accountability Agreements (MSAAs) have been put in place to hold Community Sector Service (CSS) agencies to account for services receiving public funding in Ontario. The MSAA seeks to support financial and performance accountability, requiring CSS agencies to report on their performance quarterly. The MSAA is an expenditure policy tool that has undergone several iterations, each informed by negotiations between the Ontario Ministry of Health and Long-Term Care (MOHLTC), the province's regional authorities—known as Local Health Integration Networks (LHINs)—and organizations/associations representing CSS agency interests. This approach to accountability is consistent with a broader focus on the government role as 'steering' service delivery rather than 'rowing.' The MSAA offers a standardized, politically acceptable approach to accountability. However, the MSAA relies heavily on performance indicators that may not adequately reflect quality care. The MSAA exemplifies the tension between the need for strong standardized accountability requirements for publicly-funded health service providers and the need for services that meet the needs of their communities.

*Les ententes de responsabilisation en matière de services multi-sectoriels (ERS-M) ont été mis en place pour que les centres d'accès aux soins communautaires (CASC) recevant des financements publics en Ontario puissent rendre des comptes. Les ERS-M visent à obtenir des redditions de compte financiers mais aussi à responsabiliser les centres sur leur rendement en leur demandant des rapports trimestriels sur leur rendement. L'ERS-M est un instrument de politique budgétaire élaboré par itérations successives, reposant sur des négociations entre le Ministère de la Santé et des Soins de Longue Durée de l'Ontario, les autorités régionales de la province—connues sous le nom de Réseau Local d'Intégration des Services de Santé (RLISS)—et les organisations ou associations représentant les intérêts des CASC. Cette façon d'appréhender la responsabilisation s'inscrit dans un plan d'ensemble visant à concentrer le rôle du gouvernement sur le « pilotage » des services plutôt que sur la « manoeuvre » de leur production. L'ERS-M propose une méthode de responsabilisation normalisée et acceptable politiquement. Cependant, l'ERS-M fait un usage intensif d'indicateurs qui peuvent ne pas refléter correctement la qualité des soins. L'ERS-M est une bonne illustration de la tension existant entre le besoin d'imposer des standards stricts de responsabilité pour les fournisseurs de services financés sur fonds publics et l'adéquation de ces services aux besoins locaux.*

### Key Messages

- Standardized accountability tools for organizations that receive public funding allow for equal treatment but do not take into account contextual differences in service delivery.
- Accountability requirements do not necessarily support high quality service delivery; as such, attention needs to be paid to the types of performance indicators that are in place and whether they capture important aspects of service delivery as identified by funders, providers and users.

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- *Les outils de responsabilité normalisés pour les organisations recevant des financements publics assurent l'égalité de traitement mais négligent les différences de contextes dans lesquels les services sont fournis.*
  - *Les exigences de responsabilité ne permettent pas toujours d'atteindre la meilleure qualité de service; il faut donc analyser soigneusement le type d'indicateurs de performance mis en place pour voir s'ils capturent les aspects de la qualité des services jugés importants par les financeurs, les producteurs, et les utilisateurs de services.*

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# 1 HEALTH CARE ACCOUNTABILITY REFORM IN ONTARIO: THE CASE OF MULTI-SERVICE ACCOUNTABILITY AGREEMENTS (MSAAS)

The Ontario Ministry of Health and Long-Term Care (MOHLTC) funds many privately-delivered healthcare services (including hospitals and community care) through a series of regional authorities, known as Local Health Integration Networks (LHINs). Since 2006, the MOHLTC and LHINs have been seeking to strengthen accountability for the delivery of health care services by health care service providers (HSPs) through the adoption of a series of sector-specific Service Accountability Agreements (SAAs).

The Canadian Healthcare Association defines accountability as “the relationship that exists when one accepts responsibility that has been conferred and the duty to report back to the person or body that conferred it” (2001, 3). Accountability tools like the SAAs are often put in place as a means to promote continuous improvement in the use of resources, while supporting government authority (Aucoin and Jarvis 2005). Even though accountability tools (like performance reporting) may be useful to help strengthen funding relationships like those between the LHINs and HSPs (Bergsteiner and Avery 2009), they can also be onerous, costly, and ineffective for both parties in an accountability relationship (De Vries 2007).

In this article, we focus on the Multi-Sector SAA (MSAA) as an accountability tool that is part of broader MOHLTC accountability reform efforts. The MSAA is used to hold health service providers, specifically community service sector (CSS) agencies, to account for delivery of LHIN-funded community care services. By focusing on this single tool we can examine the broader accountability reform effort while taking into consideration contextual and organizational factors unique to the CSS sector that may affect the adoption of this type of accountability instrument. In this article we will describe the MSAA, its history and context, and offer a critique of this accountability tool with particular attention to the contextual factors unique to the CSS sector that affect the adoption and implementation of accountability tools.

## 2 THE MSAA DEFINED

### 2.1 Goals of the MSAA

SAAs in general are intended to ensure the delivery of the highest quality of care for the lowest cost while ensuring sustainability of the health care system (Ontario’s LHINs 2013a). The MSAA primarily promotes financial accountability (ensuring procedural compliance), by requiring CSS agencies to follow provisions regarding: how LHIN funding is used, how funds are managed, the adoption of accounting and management standards, and conducting annual financial audits. The MSAA additionally promote performance accountability

(supporting improved service delivery) by holding CSS agencies to account to performance indicators. However, performance targets focus mainly on access to services (e.g., provision of services in French, and provision of services across a particular geographic area). Performance reviews are undertaken by the LHIN on an ad hoc basis in reaction to missed targets and/or client complaints.

## 2.2 Reporting requirements

The MSAA is enforced through reporting requirements and follow-up measures. CSS agencies bear the administrative costs associated with required quarterly financial and performance reporting to their LHIN. Missed performance or financial targets may trigger meetings between the LHIN and the CSS agency, and potentially the implementation of a performance improvement plan. In extreme instances where there is a material breach of contract, an MSAA can be terminated by the LHIN (e.g., misuse of funding; failure to provide services; failure to implement or follow a performance agreement, improvement process or transition plan).

## 3 HISTORY AND CONTEXT

In Canada, many health care services, including community care services, are financed and delivered using a *public-contracting model* in which there is public financing for a subset of care, with care being delivered by both not-for-profit and for-profit private providers (Docteur and Oxley 2003). The *Canada Health Act*, 1985 (federal legislation that sets out criteria that must be met by provinces and territories in order to receive federal government funding) only requires that provinces and territories cover ‘medically necessary’ physician and hospital services. As a result, it is up to the discretion of each province to determine how and if community care services will be provided or funded by the government. Most provinces have private for-profit and not-for-profit home and community care services available and some have services publicly available (Marchildon 2013).

Community care services, often delivered alongside home care services (which tend to be professional services like nursing), can include supports that help individuals of any age with mental or physical disabilities to receive the care they need while living at home (Commission on the Future of Health Care in Canada 2002). Community care services are non-professional services delivered by unregulated workers and can include day programs, Meals on Wheels, and friendly visitor programs (Health Canada 2013). Other community services can include transportation, foot care, security checks, recreation/social programs, lawn and home services, and respite care.

In Ontario, clients can access community care services from a wide array of home and/or community care service providers through different access points and eligibility requirements (Williams et al. 2009). Service costs vary widely and payment comes from a mix of public and private sources (including private insurance and out-of-pocket payments). Community

care services were originally under the purview of the Ministry of Community and Social Services, with many services being provided by grassroots organizations that relied heavily on volunteers (Baranek, Deber & Williams 1997). A series of long-term care system reforms that occurred over the 1980s-90s resulted in CSS services being included in the home care service delivery portfolio, and resulted in the MOHLTC funding a portion of these services for eligible individuals. Individuals can (and do) supplement publicly funded care with privately paid services, often from the same providers (*Ibid.*)

In 2006, the Ontario MOHLTC followed the Canadian trend to set up regional authorities and divided the province into 14 geographically-based LHINs under the *Local Health System Integration Act, 2006 (LHSIA)*. Regionalization was intended to increase the responsiveness of the health system to the needs of local communities by planning, funding and integrating services at a regional level (Ontario LHINs 2013b), then allocate to health services in their region including acute care hospitals, long-term care, mental health and addictions services, Community Health Centres, Community Care Access Centres (CCACs) and CSS.

## 4 FACTORS THAT INFLUENCED THE ADOPTION OF MSAAS

Long-term care system reforms that occurred over the 1980s and 90s in Ontario laid a foundation for the use of MSAAs as an accountability model. Reforms began in 1986 with the Liberal government's 'one-stop shopping approach' to service delivery, followed by the NDP government's multi-service agency model in 1994. The NDP model raised significant opposition which set the stage for the Progressive Conservatives (PC) government to introduce a competitive-management model in 1995 in which the MOHLTC provides global budget funding to agencies to provide services (Baranek, Deber & Williams 1997) with little specificity in terms of how they are to be delivered. These PC reforms were aligned with neoliberally-influenced governance reforms, termed New Public Management (NPM), that were occurring at the time. The 'reinventing government' philosophy of NPM asserts that "'steering' (policy determination) should be separated from 'rowing' (the operation of programs and the delivery of services)" with the role of the government being to steer rather than row (Thomas 1998, 370).

The foundation of government as 'steering' rather than 'rowing' service delivery remains. The creation of the LHINs has provided a financing and delivery model that allows the MOHLTC to 'steer' services through funding, while leaving the 'rowing' or delivery aspect to publicly-funded HSPs. An important feature of this is the need, on the part of the LHIN, to ensure accountability for funded services. Under the *LHSIA* each LHIN must enter into a performance agreement with the MOHLTC; in turn, they must enter into SAAs with each of the local HSPs they fund. The MSAA is the primary way in which accountability is ensured by the LHINs for publicly funded CSS services.

Accountability for the CSS sector gained added importance in 2007, when the MOHLTC announced the Aging at Home (AAH) strategy which aimed to help seniors age at home by providing a wide range of home and community support services. Nearly \$1.1 billion was invested towards community-based services for seniors (MOHLTC 2013). With ongoing concerns regarding health system sustainability and rising health care costs, the use of accountability measures like the MSAA as a means to ensure appropriate use of public money have become increasingly important.

## 5 HOW THE MSAA WAS IMPLEMENTED

There have been two versions of the MSAA since its inception, the first covering the period from 2009-2010 and the most recent covering the period from 2011-2014. At the time of writing, negotiations for the third version of the MSAA were underway. Agreement templates are negotiated between the MOHLTC, LHINs and interest groups representing CSS agencies (e.g., Ontario Community Support Association). Individual agreements between the LHINs and CSS agencies use the template as a starting point and draw on local HSP Community Accountability Planning Submissions (CAPS) to fill in details. The CAPS indicate program(s) the organization wishes to have funded, how much funding it requires for those programs, and evaluation and measurement of services (LHIN Collaborative 2013). The CAPS is negotiated then translated into an MSAA between the LHIN and the CSS agency.

Currently, a comprehensive database of Ontario-based CSS agencies is not available; as such it is difficult to determine what percentage of CSS agencies in Ontario are funded under the MSAA. However, in a previous survey of CSS agencies in Ontario conducted by the authors (Steele Gray et al. 2014) it was found that 83% of 114 agencies surveyed held MSAs at the time of the survey. In terms of funding, of surveyed agencies that received funding from the LHINs, 26% received the majority of their funding (80-100%) from the LHIN (*Ibid.*).

The MSAA is an example of a government expenditure policy tool as the MSAA is only applicable to HSPs that receive funding through the LHINs. As the MSAA includes reporting requirements, the MSAA can also be viewed as government exercising its authority (Hood and Margetts 2007) with a tool that is more coercive than expenditure instruments alone.

The MSAA is voluntary in the sense that CSS agencies can choose whether to seek public funding, but they are mandatory in the sense that organizations must adhere to accountability demands to receive funding. Organizations dependent on public funding may perceive these demands as mandatory. In previous work conducted by the authors (Steele Gray et al. 2014) it was found that many organizations under the MSAA felt financially dependent on the LHIN.

There have been some challenges with implementing the MSAA, which are discussed as

part of the analysis of the accountability tool that follows.

## 6 ANALYSIS OF THE MSAA AS AN ACCOUNTABILITY TOOL

The MSAA represents an accountability tool grappling with a fundamental tension between the need for a strong standardized accountability for public funds, and the need to accommodate contextual differences with regard to service delivery. Given the grassroots nature of many CSS agencies, there is heterogeneity regarding the types of services offered, how services are delivered, the populations served, and the geographical region or catchment area of the agency. Although the MSAA allows for some tailoring to occur through the CAPS process, the overall MSAA requirements (e.g., reporting requirements and stipulations regarding use of funding) are largely fixed. Many of the fixed MSAA requirements can become overly burdensome for some agencies (particularly small poorly resourced agencies) and key aspects of service delivery (particularly for rural agencies or those delivering services to unique populations) are not captured as part of the reporting requirements (Steele Gray et al. 2014). This tension is highlighted by findings from a 2011 survey of CSS agencies, where 43.75% of organizations receiving 80-100% of their funding through the MSAA reported that they did not intend to apply to the MSAA in the future—suggesting that CSS agencies were also avoiding the MSAA despite high financial dependence (*Ibid.*).

A SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis of the MSAA is offered in Table 1 (from the perspective of the LHIN) and Table 2 (from the perspective of CSS agencies).

Table 1: SWOT Analysis LHIN Perspective

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> <li>● Supports equal treatment of CSS agencies under MSAA</li> <li>● Allows government to maintain its ‘steering’ role while leaving ‘rowing’ to the CSS agencies</li> <li>● Government use of expenditure tools tends to be politically acceptable.</li> </ul>	<ul style="list-style-type: none"> <li>● Performance indicators do not capture key aspects of service delivery—identified as an issue by both CSS agencies and the LHINs (<i>Ibid.</i>).</li> <li>● The MSAA only impacts CSS agencies that receive public funding.</li> </ul>

OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> <li>• Opportunity to support LHIN, and broader MOHLTC level goals by building them into agreements.</li> <li>• Opportunity to support best practices in community care service delivery (e.g., supporting caregivers, targeting strategies, care coordination).</li> </ul>	<ul style="list-style-type: none"> <li>• Added burden of accountability requirements result in small agencies losing funding (<i>Ibid.</i>). Small agencies often serve specific community needs (e.g., rural home-based palliative care); a loss of funding could result in the loss of these specified services.</li> <li>• The MSAA is not evaluated in terms of its usefulness as an accountability tool.</li> </ul>

Table 2: SWOT Analysis CSS Perspective

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> <li>• Supports equal treatment of CSS agencies under MSAA</li> <li>• There is CSS agency representation in the development of the MSAA template.</li> <li>• The MSAA has few stipulations regarding how services are to be delivered.</li> </ul>	<ul style="list-style-type: none"> <li>• Standardization does not allow for responsiveness to organizational contexts.</li> <li>• Poorly resourced organizations have difficulty meeting administrative demands, potentially affecting service delivery.</li> <li>• Performance indicators do not capture key aspects of service delivery—identified as an issue by both CSS agencies and the LHINs (<i>Ibid.</i>).</li> </ul>
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> <li>• Opportunities for sharing administrative costs through back-office integration requirements attached to MSAA. However, this has been found to be of less benefit to small agencies (<i>Ibid.</i>).</li> </ul>	<ul style="list-style-type: none"> <li>• Administrative demands associated with MSAA (i.e., reporting requirements) may not be sustainable for smaller agencies receiving funding.</li> </ul>

Our analysis of the MSAA suggests that policymakers need to be aware of contextual factors associated with the health care sector to which they are applying new accountabil-

ity policy instruments. Standardized tools may be more applicable to sectors characterized by greater organizational homogeneity than sectors like CSS, which are characterized by greater organizational heterogeneity. In the CSS sector, the standardized MSAA tends to favour the larger better-resourced organizations over smaller poorly-resourced ones, potentially leading to the loss of funding for small agencies that meet specific community needs. Furthermore, this type of tool tends to support traditional vertical accountability relations, potentially limiting broader system integration which would require horizontal accountability approaches.

The MSAA does, however, offer some important opportunities, namely the potential to support best practices in home and community care service delivery. LHINs could work to improve performance indicators and MSAA requirements that support strategies such as targeting high-needs populations and improved care coordination; strategies which have been found to support individuals in their home for longer, potentially leading to system-level cost savings.

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## 8 FOR MORE DETAIL

### 8.1 Accountability

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