Regionalization: What Have We Learned?

Gregory P. Marchildon

Commentary from Yves Bergevin, Gwyn Bevan, Yvonne Boyer, Adalsteinn D. Brown, Jean-Louis Denis, Stephen Duckett, Keesa Elicksen-Jensen, Katherine Fierlbeck, Bettina Habib, Derek Kornelsen, Josée G. Lavoie, C. David Naylor, Peter W. T. Pisters, Jean Rochon, Denis Roy, Stephen Samis, Tim Tenbensen, Karsten Vrangbaek and Lloy Wylie
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The contributions to this issue of Healthcare Papers provide a clear picture of the strengths and weaknesses of regionalization efforts. The guest editor for this issue – Professor Greg Marchildon – summarizes the current environment well when he states that, for want of something better, “regionalization remains the most viable means” to the improvement of healthcare system performance in Canada.

It seems that governments agree with this summary. The last decade has seen a spate of efforts to rework the architecture of Canada’s healthcare systems. Provinces have regrouped the sets of providers included under regions (e.g., Quebec), redrawn regional boundaries (e.g., Alberta) or restated the accountabilities of regions (most provinces). Even Ontario – for a long time the control group for Canadian experiments in regionalization – created the local health integration networks (LHINs).

Ten years later, Ontario is considering even more sweeping consolidation of healthcare providers and powers under the LHINs.

To justify regionalization, policy makers commonly cite a greater focus on public health and health promotion, cost-saving consolidation of administrative processes and the promise that health services will finally reflect how patients receive care from different providers as
they move through the system. Unfortunately, policy makers sometimes conflate regionalization – the lumping of providers under regional governance – with integration or the organization of care around patient needs. Like regionalization, integration may sound like jargon. However, many, if not most, patients in Canada still experience the healthcare system as a series of disconnected siloes. Providers too are frustrated when lack of integration undercuts the ideal of coordinated and continuing care for the changing health needs of individual patients. When care providers work together in a way that aligns their professional practices, information systems, incentives and cultures, they can provide health services faster, more reliably and with better outcomes. For the patient, that means fewer tests and unnecessary visits, better communication and a lower risk for medical errors.

Regionalization can support integration, but it is neither sufficient nor necessary to improve integration and health system performance. In this issue, Yves Bergevin and colleagues provide a comprehensive review of global experiences in regionalization and conclude with seven lessons that talk about how regionalization turns into integration and a clearer focus on the patient. These lessons emphasize that the best regionalized systems do more than bring budgets together. They also change the way monies flow, creating incentives for integrated care, opportunities for reinvesting based on measured performance and a necessity for stronger clinical leadership. They also point, somewhat painfully, to the fact that we need a second phase of regionalization reforms that go well beyond current debates about who controls whom and who gets to hold the money.

Here is what that second phase of reform might ideally involve:

First, real integration needs to occur. That’s especially true when so many patients receive sophisticated and comprehensive healthcare services from multiple providers. Better-coordinated care will result in improved quality, enhanced patient experience and lower societal costs. A rapid way forward is for provinces to encourage and financially support new consortia of institutions and other local care providers that grow from coalitions of providers focused on meeting community needs. These networks of providers will thrive if they are big enough to provide comprehensive care and achieve economies of scale, and if the right incentives are put in place.

That brings us to reinvestment for performance. Each year that a network improves care for patients in a meaningful way, it should be able to reinvest these savings back into further system improvements. However, to ensure that the improvements are real and corners aren’t being cut, ministries, regions and providers must collaborate to generate detailed public scorecards for each network – scorecards that focus on outcomes like health status, patient experience and safe care. Making quality improvement the first job of regions is a key lesson from the US experience with accountable care organizations (ACOs) that is too often neglected when we try to simultaneously juggle cost control and quality in Canada.

These changes would go a long way to rewarding achievement and creating a more innovative and dynamic culture within our provincial healthcare systems. They play to the best side of Canada’s doctors, nurses and other healthcare professionals by recognizing and rewarding better care rather than just volumes and costs of services. And, if these changes focus more attention upstream on population health status, then health promotion and maintenance in turn may get greater attention.

The third step is also crucial. Healthcare systems across the country urgently need to strengthen what is often called
“clinical governance.” In top-performing health systems, doctors, nurses and other health professionals are constantly and closely engaged in leading efforts to improve care. They receive training, have access to data on care and are supported in improvement efforts, so that quality improvement is seen as part of the clinicians’ jobs, not just an extra task to be pursued when the last patient has been seen. These systems also invest in leadership development, so that more doctors, nurses and other providers can take a big picture view, use data wisely, embrace innovations in healthcare and generate and test their own ideas for improving the system.

Moving from regionalization to integration is tough sledding at a time when most ministries of health face dramatic and continuing financial pressures. More than a few provinces are at loggerheads with their doctors as they try to change the organization of care and limit physician expenditure. Creating new structures may be part of the necessary reforms to our system, but it should not be the only part. The faster we can get to that next phase of reform with its possibilities of better integration, smart reinvestment and reporting, and stronger clinical governance, the faster Canada can regain its leadership in healthcare.

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Regionalization: What Have We Learned?

INVITED ESSAY

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ABSTRACT

Regionalization is arguably the most significant health reform in Canada since medicare. Although a majority of provinces continue to have regionalized systems in Canada, the policy is more contested today than it was a decade ago. Since Ontario’s implementation of local health integration networks (LHINs) in 2006 and Alberta’s elimination of regional health authorities (RHAs) in favour of Alberta Health Services in 2008, Canada has had differing approaches to regionalization. However, due to the centralization of physician budgets in provincial health ministries, primary care has not been integrated into any regionalization model in Canada. This factor has severely constrained the performance of RHAs and their ability to meet their respective legislative mandates. Moreover, the lack of research on regionalization has meant that provincial governments are working from an extremely limited evidence base on which to make critical decisions on the structuring of health systems in Canada.

Over a decade ago, this journal devoted an issue to the Canadian experience with regionalization (Lewis and Kouri 2004). The titles of the articles not only reflected consensus on the merits of regionalization but also great optimism about the future from “a promising heritage to build on” (Denis et al. 2004) and “an opportunity for improving management” (Levine 2004) to implo
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(Davis 2004) and bring the full “continuum of care” (Ward and Bedford 2004) under the control of health regions.

In 2004, regionalization was in its ascendancy as a pan-Canadian policy. Every province except for Ontario had restructured its health system into geographically-based organizations, which had been delegated by their respective governments to organize and manage the provision of a broad range of health services and programs. Two years later, as if to emphasize the consensus, Ontario joined the rest through its own version of regionalization with the implementation of what it would call local health integration networks, or LHINs (MacLeod 2015). The structural change made by the introduction of regional health authorities (RHAs) seemed to have become a permanent part of the Canadian landscape.

What a difference a little more than a decade can make. Since that first issue, three provincial governments – Prince Edward Island (2005), Alberta (2008) and Nova Scotia (2015) – eliminated RHAs in favour of a single, centralized delivery agent for the entire province. New Brunswick (2008) and Manitoba (2012) dramatically reduced the number of RHAs, while other provincial governments established or extended province-wide services and infrastructure in an effort to gain greater economies of scale and scope. In Quebec, the provincial government recently removed the second layer of its two-tier regionalized system in order to shift resources from administration to front-line delivery. In all jurisdictions, the efficacy of regionalization is being questioned on multiple fronts by governments, the media and the general public (Marchildon 2015).

The most interesting aspect of this change is the extent to which major decisions on the reorganizing of health systems have apparently been made on minimal evidence. The prime example of this was the Alberta government’s abrupt decision to replace its health regions with a single health authority and the chaos that ensued for a year or two afterward. The reasons for the change were never clearly articulated and Alberta Health Services would have to evolve without the benefit of a detailed implementation plan (Donaldson 2011).

What the future holds is anyone’s guess, but we can no longer assume that a devolved RHA structure will be an identifying feature of health systems within Canada. In fact, the only thing we can be sure of is that we are likely to experience even more structural and organizational change in the next few years, as governments cope with fiscal pressures in a low economic growth environment and the promise that integration can improve quality and reduce cost at the same time.

This issue is motivated by twin objectives. The first is to determine what we have learned more recently from regionalization, in particular the impact of regionalization on health system performance and outcomes as well as the health of the population served by RHAs. The second objective is to address some outstanding questions by examining analogies within Canada or the experience with regionalized structures in other countries. This introductory essay sets the stage by summarizing the evolution of regionalization, the original policy goals of the reform and the challenges posed by regionalization.

Evolution and Objectives of Regionalization

Policy experts had been urging provincial governments to consider establishing regionalized structures for the administration and delivery of healthcare for decades before the 1990s. As early as 1944, for example, Professor Henry Sigerist of Johns Hopkins University delivered a report to a newly-elected social democratic government in Saskatchewan, where he recommended dividing the province into
In the mid-1960s, the Royal Commission on Health Services chaired by Justice Emmett Hall recommended a mild form of regionalization through local health planning councils (Canada 1965). This was followed by a more full-blooded recommendation in favour of regionalization by the Conference of Ministers of Health (1969). Driven by concerns about managing the cost of universal medical care then being introduced throughout Canada, federal and provincial health ministers concluded that regional authorities were required to address the inefficiencies produced by uncoordinated health organizations and providers. With universal medical care in place, provincial governments had to pay the hospital and medical care bills without any effective managerial control. The creation of public bodies responsible for managing the health budgets for a population within a defined geographic area was perceived to be the most effective way to exert some budgetary control and facilitate more integrated service delivery in order to enhance the quality of health services. In the words of the federal Minister of Health, regionalization would achieve on behalf of all governments in Canada “the common goal of restraining the rate of increase in health service costs while maintaining and improving the quality of care” (Conference of Ministers of Health 1969: 1).

Although five provincial governments (Ontario, Quebec, British Columbia, Nova Scotia and Manitoba) called for public studies concerning the potential of regionalization in their respective provinces by the early 1970s, it would take 20 more years for regionalization to be introduced in Canada. The onset of a deep recession in the early 1990s coming after decades of deficit financing put most provincial governments into a precarious fiscal position. As part of a broad program of public expenditure cuts, almost all provincial governments introduced regionalized health systems. They did so in order to exert some cost controls, reduce excess capacity in terms of hospitals and human resources and bend the cost curve by shifting the emphasis from acute and institutional care to primary care, health prevention and the more upstream determinants of health.

The initial years were marked by some false starts in terms of the quality of RHA leadership and senior management.
RHAs rather than providing strategic goals and direction. In the language of the new public management, ministries of health were to steer and the RHAs to row, but there were too many instances of ministry “interference” in the daily operations of RHAs – often in the midst of crises where ministers of health had to face questions and demands from the media and opposition members in the legislature.

Based on public releases at the time RHAs were first introduced, provincial governments were attempting to achieve at least seven distinct objectives through regionalization:

1. Integrate and coordinate a broad range of health services (*vertical integration*).
2. Consolidate and rationalize hospital services in order to reduce costs (*horizontal integration*).
3. Shift emphasis and resources to illness prevention and health promotion (*population health*).
4. Decrease variation and improve service quality through evidence-based practice.
5. Decentralize resources to facilitate better match with population needs.
6. Decentralize decision-making to increase public participation and input.
7. Increase accountability by having an administrative body (RHA provider) report on performance and outcomes to the health system funder and steward (provincial government through health ministry).

These objectives are almost identical to the objectives identified over a decade ago by Lewis and Kouri (2004). While it may be almost impossible to determine the relative weight put on these objectives by individual provincial governments at the time, these objectives provide at least a starting point for determining the criteria against which we would assess the success or failure of regionalization. What is even more fascinating is the lack of research interest in Canada in assessing what has been a remarkable natural experiment in structural reform across jurisdictions. Indeed, judging by publication output, there has actually been a decline in research on regionalization during the past 15 years relative to the research that was done on the subject when regionalization was first planned and implemented (Bergevin et al. 2016).

By the end of the 1990s, the managerial (if not leadership) challenges experienced when regionalization was first implemented had diminished and governments began to revise the structures they had built. Some provincial ministries concluded that further economies of scale and scope could be achieved and administrative overhead lessened by consolidating RHAs. As can be seen in Table 1, there has been a distinct trend to greater centralization.

**Regionalization Models**

Before embarking on a detailed discussion of regionalization in Canada in the following essays, it is worth determining where Canadian approaches to regionalization fit in terms of the three principal models of regionalization we see in other higher-income countries. As can be seen in Table 2, regionalization in Canada has been administrative rather than political in nature.

In no case have provincial governments delegated authority and responsibility for healthcare administration and delivery to local governments, nor have they created regional democratic structures to achieve this purpose. In one sense, this is understandable. Canada already is a decentralized political federation with most of the authority and responsibility for healthcare residing with provincial governments. In contrast, local governments in Canada have no constitutional status and, relative to other OECD countries, are limited in terms of revenue generation and responsibility for health programs and services.
The Canadian approach may have been unique in one respect. Coverage in Canada is divided between universal coverage for hospitals and physician care, and extended health benefits for community and long-term care – what the Europeans call social care.

Regionalization provided a potential vehicle to coordinate services across these two very different coverage regimes with the exception of the provincial prescription drug plans. This was an understandable exception, since these plans, at least historically, did not involve a service or facility component. However, what was illogical – even if understandable from a political perspective – was the omission of primary care.

Although primary healthcare was made part of the legislative mandates of RHAs, not one government created a mechanism for RHAs to coordinate, much less integrate, primary care into the new managerial system. As the main deliverers of primary care,
physicians retained their status as independent practitioners paid mainly on a fee-for-service basis through contracts negotiated by medical associations and provincial governments. Organized medicine throughout Canada made it clear that it would never support a change in which its members would be made accountable to RHAs through contract or employment arrangements. The end result was that RHAs were unable to manage perhaps the most crucial piece in the continuum of health (Marchildon 2015).

The one conundrum posed by regionalization wherever it has been implemented is its linkage with integration. It is true that the reform has suffered from the naïve assumption that regionalization would automatically increase health system integration and health service coordination. Indeed, the reform was conceived as the organizational means to achieve precisely those ends. In reality, RHAs have had tremendous difficulty in replacing health service silos with a seamless continuum of care; indeed, some RHAs seem to replicate the very organizational and service silos that had existed prior to regionalization. The real question is whether the service user experience has been altered by regionalization. Some analyses (e.g., Bergevin et al. 2016) suggest that it has, but only to a degree; that much more integration and coordination is required for regionalization to achieve its purpose. The truth is that there is so little study of this phenomenon that we hardly know in any objective sense what regionalization has changed in terms of coordination and integration.

At the same time, I would disagree with those who have drawn what I think is a false dichotomy between integration on the one hand and regionalization on the other. Over 15 years ago, it was argued in this journal that the characteristics posited in the ideal model of integrated delivery systems developed by Shortell et al. (1993, 1994) in the US differed substantially from the characteristics of the then current model of RHAs in Canada (Leatt et al. 2000). However, the integrated delivery system characteristics put forward by these authors were based on an ideal of coordinated healthcare as developed on an ideal consumer-based model of managed care in the US, while the RHA characteristics were based on the reality of early regionalization in very different institutional environments.

What we really need is a study of the common characteristics of integrated delivery systems across countries that share reasonably similar institutional environments, and then compare these to regionalized systems in Canada to determine to what extent and
with what results regionalization can lead to integration. My hope is that, over the coming years, we will see an increase in scholarly research, as well as more rigorous evaluation within and outside governments of the continuing experiment with regionalization in Canada. As Table 2 illustrates, we have at least two models of regionalization that could be compared in terms of performance and outcomes. These studies would provide the basis for future policy change that is more evidence-informed than what we see at present.

We can no longer afford to be so parochial in our thinking about regionalization. The Canadian experience is simply too limited, both in terms of scope and time. For this reason, the first group of authors in this issue was given a mandate to describe some relevant experiences with regionalization outside Canada and the possible lessons these may hold for provincial governments here. The second set of authors was asked to provide their observations on the recent Canadian experience, while a third group was asked to speculate on how regionalization might be reshaped in order to deliver on its original promise. I hope that these respective reflections on regionalization will be the start of a major new initiative to study the impact of regionalization on healthcare in Canada.

Notes
1. The government of Prince Edward Island eliminated RHAs in 2005, but did not create Health PEI until 2010.

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Healthcare Papers
What Can We Learn from the UK’s “Natural Experiments” of the Benefits of Regions?

COMMENTARY

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ABSTRACT

Marchildon highlights the lack of evidence on policies of regionalization in Canada: with regionalization being in favour in the 2000s followed by disillusion and the abolition of regions by some provincial governments. This paper looks at evidence from the UK’s single-payer system of the impacts of regions on the performance of the delivery of healthcare. In England, regions were an important part of the hierarchical structure of the National Health Service (NHS) from its beginning, in 1948, to the introduction of provider competition, in the 1990s. Since then, in England, governments have understood that the NHS cannot be run from Whitehall and have tried to replace hierarchical control by provider competition. The consequence was that regions in England were subjected to frequent reorganizations from the mid-1990s with their abolition being announced in 2010. In contrast, the devolved countries of the UK have always been organized as “regions” in the form of their historic national boundaries. This paper argues that changes in the NHS in the UK in the 1990s and 2000s offer three “natural experiments,” in terms of funding, organization and models of governance, that give evidence of the impacts of stable regions in the UK. It also considers the lessons of this evidence for Canada.
Introduction
According to my reading of Marchildon’s (2016) account of policies on the introduction of regional health authorities (RHAs) in Canadian provinces in the 2000s, it was hoped they would better enable the provinces to make many kinds of improvements in the delivery of healthcare: better integration and coordination of a broad range of health services; more redistribution of resources from acute hospital services to illness prevention; greater use of evidence-based medicine to reduce unwarranted variations and improve quality of care; better allocation of resources to the needs of populations; greater participation in decision-making and accountability for performance. If these were indeed what provinces were hoping for, then it is understandable that they would be disappointed with the failure of regions to resolve abiding problems of all healthcare systems. This paper argues that the National Health Service (NHS) in the different countries of the UK offer an intriguing “natural experiment” as to the impacts of a stable region under different models of governance. In the English NHS, if we define regions as the next level below that of the nation, then, from the mid-1990s, the English NHS has tried to deliver healthcare to a population of over 50 million without a stable region. But in each of the UK’s three devolved “countries” – Scotland, Wales and Ireland – each NHS has a stable region in the form of their historic national boundaries (with populations of 5 million, 3 million and nearly 2 million, respectively).

The following sections explain the nature of three natural experiments between England and the devolved countries that enable comparisons to be made from having stable regions, summarize evidence from studies of these experiments and discuss the implications of that evidence for the debate about regionalization.

Regions in England and the Devolved Countries
It seems that the predilection of politicians in Canada to impose top-down structural reforms in the absence of evidence to justify them, as described by Marchildon (2016), is an even more serious problem in England. Indeed, Timmins (2013: 6) suggests that the “disease” of the English NHS might be described as “organisation, reorganisation and redorganisation.” So, if Jane Austen were to chronicle the recent story of the NHS in England, she might well begin by saying: “It is a truth universally acknowledged that a Secretary of State for Health in possession of the English NHS is in want of a top-down reorganisation.” This “truth” was put to the test when the Conservative and Liberal parties, in forming the Coalition Government after the 2010 elections, agreed and published their program for the government of May 2010, stating their second priority for the NHS in England to be: “We will stop the top-down reorganisations of the NHS that have got in the way of patient care” (Cabinet Office 2010: 24). But this public commitment by the Coalition Government did not deter the new Secretary of State for Health in England, Andrew Lansley, whose white paper, Equity and Excellence: Liberating the NHS (State for Health 2010) published in July 2010, “launched arguably the biggest restructuring it (the NHS) had seen in its 63-year history” (Timmins 2012: 3). The Chief Executive of the NHS famously described this organizational change as so big “you could probably see it from space” (Nicholson 2010).

From the start of the NHS in 1948 to the 1974 reorganization, there was, however, minimal organizational change. The 1974 reorganization was justified in aiming to remedy flaws in the original organization design of the NHS in England and Wales, as created in 1948, in which providers were divided into four...
organizational silos (and these divisions were mirrored in Scotland and Northern Ireland) for: teaching hospitals, non-teaching hospitals, general practitioners (GPs) and community health services. The 1974 reorganization created organizations defined by populations, not providers across the countries of the UK. In England, undergraduate teaching hospitals were moved into the regional structure of 14 RHAs, and three sub-regional organizations were defined for the same geographical areas in the hope that this would better enable a basis for the close working between hospital and community health services, primary healthcare, and social services. However, those geographical identities were lost by the 1982 reorganization of hospital and community health services (Levitt and Wall 1984).

The destabilization of regions in England followed the introduction of the “internal market” in 1991. This changed the NHS in each country from a hierarchical structure to a market, with “purchasers” that contracted with, rather than ran, “providers” (Secretaries of State for Health, Wales, Northern Ireland and Scotland 1989). In England, RHAs, were abolished in 1996 and replaced by eight regional offices (Ham 2000: 1); which in turn, in the 2000s, were succeeded by four regional directorates of health and social care, then 28 and later 10 Strategic Health Authorities (SHA) (Audit Commission and Healthcare Commission 2008: 16). The Lansley reforms proposed in 2010 aimed to empower GPs as purchasers to choose between any qualified provider subject to national regulators. These reforms saw no role for any regional presence in its organizational chart for its new system of governance (Secretary of State for Health 2010: 29). In contrast to England, each devolved country had a stable region defined by national boundaries.

The (New) Labour government elected in 1997 made four major policy decisions that had a profound influence on the health systems of the UK for the following decade: First, it abolished the idea of provider competition, but maintained the purchaser/provider split in England and Wales. Second, it enacted devolution to Scotland, Wales and Northern Ireland so each country’s government could decide its own policies for its NHS. Third, it increased NHS spending in England in real terms by five per cent a year, which fed through (by the Barnett formula) to increased spending on each country’s NHS. Fourth, it introduced into the English NHS the system of annual performance (star) ratings with sanctions for failure and rewards for success. Scotland led the way for the devolved countries in abandoning the purchaser/provider and going back to a hierarchical system in which their Health Boards ran providers. From 2006, the government reintroduced provider competition into the English NHS, and the Lansley reforms sought to entrench that policy in primary legislation (Bevan 2014; Timmins 2012).

Three Different Natural Experiments in the Health Systems of the UK
This section explains how the period from 1996 to 2012 offers three different kinds of natural experiments for examining the impacts of regions. These three periods were as follows:

1. **1991 to 1996: before devolution.** In this period, the English NHS was administered by RHAs and all countries had implemented the policies of the internal market. The natural experiment was in differences in per capita spending on the NHS, which was markedly higher in Scotland (by 25%) and Wales.
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(by 18%) than in England (Dixon et al. 1999).

2. 2000 to 2006: immediately after devolution. In this period, no government sought to improve performance by provider competition. Although England still had lower per capita spending on healthcare than the devolved countries, the more interesting natural experiment was in the governance of performance against targets. England was the odd man out in two ways: First, its regions lacked stability; second, only in England was failure by providers to achieve government targets for quicker access to health services penalized through public reporting and performance management (in what became the regime of annual “star ratings”) (Secretary of State for Health 2000). In the devolved countries, such failure was widely perceived to be rewarded with extra funding (Bevan et al. 2014).

3. 2006 to 2012: when devolution has become well established. In this period, levels of per capita funding in the northeast region of England were by 2011/12 similar to that of Scotland and the most interesting natural experiment was between different models of governance that had developed in England and Scotland. In England, the policy emphasis for improving performance was on provider competition without a stable region (Secretary of State for Health 2002). In Scotland, the government emphasized a “tougher and more sophisticated approach to performance management” in which performance was systematically monitored with support and intervention when necessary (Steel and Cylus 2012: 113-114). In Wales and Northern Ireland, there was no evidence of similar regional governance of performance (Bevan 2014).

The Outcomes of the Three Natural Experiments

Dixon et al (1999), using data from 1995/96, examined the first natural experiment and found that crude productivity of doctors and nurses in terms of patients seen and treated were lower for doctors and nurses in Scotland and Wales than in England. Hence, the higher levels of funding in Scotland and Wales appear to have resulted in an easier working life for producers than more care for patients.

Alvarez-Roseté et al. (2005), using data from 2002/03 and Connolly et al. (2011), using data from 2006/07, examined the second natural experiment. Both studies found that providers in the English NHS still appeared to have higher rates of crude productivity. And there had been dramatic improvements in England in reducing long waiting times for access to the NHS and quicker response times by ambulance services to potentially life-threatening emergencies (Category A calls), which was not matched by the devolved countries.

Bevan et al. (2013), using time series of data, mostly up to 2011/12, for the third natural experiment, found a marked improvement in Scotland’s performance, so that it broadly matched England’s for hospital waiting times and ambulance response times to Category A calls. The performance in Wales and Northern Ireland on those measures still lagged behind England and Scotland. There was little evidence that the effort expended in England on provider competition had delivered improvements in performance. The third natural experiment suggests that when the regional government in Scotland did operate a system with sanctions for failure and rewards for success, this had the potential to outperform a system in England based on provider competition without a stable region.
Discussion
Evidence from the UK suggests that: two models of governance have proved to be ineffective, namely, stable regional governance with perverse incentives for rewarding failure, and provider competition; and an effective model is to create stable regional governance with systems of normal incentives that reward success and penalize failure. The government in England now recognizes that the English NHS cannot be run well either from Whitehall or by a regulated provider market (NHS England 2014). But there is no enthusiasm for going back to the 1974 hierarchical organizational structure. Instead, the intention is to find other means of achieving its objectives of tackling silo working. An important pilot is where the Mayor of Manchester is leading changes to integrate health and social services for the region of Greater Manchester. There seem to be two messages for the provinces of Canada: first, try to develop herd immunity from the English disease of redisorganisation; second, that the presence or absence of regions in a province is less important than the model of governance that is being applied.

References
Introduction: Is the Danish Case Relevant for Canadians?

Denmark has a long tradition of democratically governed local and regional governments with extensive responsibilities for organizing welfare state services. A major reform in 2007 created larger regions and municipalities in Denmark, which has a population of 5.6 million. Like the other countries in the Nordic region, Denmark is a small Northern European country with a strong commitment to maintaining a universal healthcare system. The Danish healthcare system has demonstrated an ability to increase productivity, while at the same time maintaining a high level of patient satisfaction.

Ongoing reforms have contributed to these results, as well as a firm commitment to innovation and coordination. Regions and municipalities in Denmark are governed by directly elected democratic councils. The Danish case is thus an example of democratic decentralization, but within a framework of national coordination and fiscal control. In spite of the difference in size and historical traditions there are also many similarities between Canada and Denmark, particularly in terms of health and social policy goals and aspirations, and in terms of the commitment to a comprehensive, universal healthcare system. These similarities provide interesting opportunities for comparison.
order to strengthen quality and economic efficiency. Regions and municipalities in Denmark are governed by directly elected democratic councils. The Danish case is thus an example of democratic decentralization, but within a framework of national coordination and fiscal control as explained below (Vrangbaek 2015, Olejaz et al 2012).

Local governments in Denmark are responsible for social services, home care services, elderly care, primary education and employment. Regional authorities manage specialized healthcare in the form of regionally owned hospitals and privately owned general and specialist practitioner clinics (Olejaz et al 2012). The governance structure of Danish healthcare underwent a substantial reform in 2007, where the previous 278 municipalities were amalgamated into 98 new and larger municipalities. The aim was that all municipalities should have at least 30,000 inhabitants. In practice, most ended up being considerably larger, and the average is now 55,000 inhabitants. At the same time, the previous 13 counties were replaced by 5 new and larger regions, with population sizes ranging from 1.6 million (Greater Copenhagen) to 600,000 (Northern Jutland). The regions assumed responsibility for specialized healthcare from the previous counties, while the municipalities gained responsibility for many other tasks, including a stronger responsibility for rehabilitation, prevention and health promotion in addition to the traditional public, infant, home care and school health tasks. The evaluation of the regional governance structure for healthcare in Denmark since 2007 is generally positive. The regionally based system has managed to contain costs and to adjust to external contingencies, such as the economic downturn following the global financial crisis in 2009. The regions have also been the key actors in a major redesign of the Danish hospital infrastructure and a successful transition of many services from inpatient to ambulatory care. This has contributed to remarkable productivity increases in Danish hospitals of 4–5% annually from 2009 to 2013.

The regions are currently managing a rationalization and redesign of the system, establishing a number of new centralized hospitals and the closing of smaller hospitals. General quality indicators show positive trends, and Denmark is at par with other similar European countries on most health outcomes. Finally, the regional structure and the reconfigured municipalities have implemented a number of initiatives to strengthen coordination and integration of care. Not all are successful, but a major benefit of the regionalized structure in Denmark is that it allows for experiments and learning across units.

In spite of the significant difference in size, there may be relevant lessons for Canadian health policy from the Danish case. In particular, it may be relevant to look at Danish policy instruments for handling multilevel governance and coordination across administrative levels. Similarly, both Denmark and Canada are facing aging populations and, therefore, need to provide better integrated services to deal with the growing number of citizens with chronic care needs. Finally, the Danish case may provide inspiration in regard to the difficult issues of how to decide and implement a major reform of the governance system.

The Structural Reform of 2007
The 2007 “Structural Reform” has been labelled “unthinkable” by several policy analysts (Bundgaard and Vrangbaek 2007; Christiansen and Klitgaard 2008, 2010). The reason is that such reform attempts historically have mobilized resistance from powerful stakeholders within the major parties and more broadly. There has historically been
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a strong commitment to local and regional democratic structures as the locus for organization of welfare services, and many politicians have started their careers in municipal and regional politics. Furthermore, administrative reforms tend to alienate a large number of public employees, that fear disruptions and changes in the wake of the reform, and in the case of centralization reforms, many citizens fear that larger units and longer distances to politicians and to service providers (e.g., hospitals) reduces their power to engage in decision-making. So how did the 2007 structural reform come about? What were the main arguments and which political constellation made it possible? The main answer from policy analyses of the reform has been that the reform was a result of a rare “window of opportunity” due to the combination of reform-minded, central-level politicians, de facto majority government, weak internal and external opposition and reduced support for decentralist ideas. Furthermore, key government actors seized the opportunity and skillfully managed the policy process to overcome resistance from important stakeholders and build a strong coalition behind the reform (Bundgaard and Vrangbaek 2007; Christiansen and Klitgaard 2008, 2010).

The main political arguments behind the reform were that larger municipalities and regions would enable more expertise and more financially robust administration of welfare services. Higher volume was expected to lead to better quality and more efficient administration. Furthermore, the politicians behind the proposal wanted to eliminate “grey zones” of overlapping responsibilities and create a unified entry point for citizens through a clearer division of labor and better coordination. There was a strong belief in “benefits of scale” in specialized healthcare and there were concerns about quality and economic “sustainability” in smaller municipalities. Finally, it was argued that this reform was necessary to prepare for the demographic transition with a growing number of elderly, chronic care patients often suffering from multiple diseases. The demographic transition also poses long-term challenges for financing of the welfare state. Although such arguments are enviable, a reform was still expected to generate opposition, not least since the previous structure had been performing rather well in terms of cost containment and quality. This meant that there was no clear “burning platform” for change. So what facilitated the process?

In the political arena, there was a unique parliamentary situation, where the government was in an unusually strong position. Although it was a minority government, it could count on support from one of the major opposition parties, which had been a long-time supporter of administrative reform. At the same time, the other main opposition parties were rather weak and did not have a unified stance concerning the reform. Another political factor was a change in the internal power balance within the major government party, which meant that the voices favoring decentralization and localism had become weaker compared to the reformist and centralist wing.

At the same time, a strong advocacy coalition group was formed with members from the industry association (“Danish Industry”), the association of municipalities (“Local Government Denmark”) and key ministers and ministries (Finance, Economics and Interior), while no major opposing coalition appeared.

... the politicians behind the proposal wanted to eliminate “grey zones” of overlapping responsibilities ...
The “Association of County Councils” obviously had strong interests in maintaining status quo, but was too late and not sufficiently strong in mobilizing support. On the contrary, within Local Government Denmark, there was a feeling that the reduction in the number of local governments (and mayor-ships) would be outweighed by gaining a stronger position and more responsibility for welfare tasks. This meant that the government could benefit from playing the municipalities against the counties, thus securing support from a major part of the decentralized political forces.

Other important elements in the management of the policy process include a tight government control of the Commission, which was established to investigate alternative options. The mandate for the Commission was relatively narrow, and the Commission was dominated by representatives of central government ministries. The Commission presented a report that emphasized expected future challenges to the health and social care systems and framed the different policy options. In the following political negotiation process, the government cleverly did not reveal its true intentions until it was too late for the opposition to mobilize resistance. Furthermore, the government guaranteed all county and municipal employees, that they would retain their jobs in the new structure, thus disarming much of the critique from this major voter group.

The government also created a process of “voluntary” amalgamations in the municipalities. This turned the local level debate into a discussion about which other municipality to join, rather than a debate about the reform itself. To reinforce the process, the government created economic disincentives for municipalities that considered not joining with other municipalities. Finally, a “liaison group” negotiated solutions in municipalities where “voluntary” amalgamation agreements could not be found.

The government also benefited from the publication of a research report showing that “local democracy” would not suffer. This had been a main concern in previous reform discussions, as there is a strong emphasis on local level democratic participation in the administration of the Danish welfare state.

Summing up, it appears that there are general lessons about advocacy coalitions, management of the policy process and framing of the political discussions in the Danish case of the Structural Reform from 2007. Some of the key arguments concerned benefits of scale, and the need to create better structures for coordination of care. The following section presents some of the instruments used to coordinate the multilevel governance of healthcare in Denmark after the reform.

**Instruments for Multilevel Governance of Healthcare in Denmark**

The Danish healthcare system can be described as a multilevel governance structure consisting of the state (ministries and agencies), the regions and the municipalities. All three levels have democratic assemblies elected in direct elections. There are interest organizations for both the municipalities (“Local Government Denmark”) and the regions (“Danish Regions”) and, although they are not a formal part of the governance system, over time, they have assumed a role as key negotiation partners for the government and as mediators and facilitators of policy development and implementation at the regional and municipal levels. The two organizations are also partners in annual “economic agreements” with the government. These agreements establish targets for the economy of the regions and municipalities and serve as forums for discussing new policy initiatives. These agreements are since 2014 entered in the context of a national “Budget Law,” whereby the national parliament establishes
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boundaries for expenditures at all levels of government, including the regions and municipalities. Budget overruns are punished by withholding state grants. The budget law and the economic agreements mean that the fiscal autonomy of municipalities has been reduced considerably, although they, unlike the regions, still have the ability to raise taxes.

In addition to this economic coordination mechanism, there is a long-standing tradition for involving regions and municipalities in policy development committees, working groups, etc. This means that most policy initiatives are negotiated across the levels when they are being developed and/or in the implementation phase. The municipalities and regions have a strong incentive to participate in these processes in order to influence the decisions. More broadly, it is important for them to continue to appear as valuable and legitimate policy partners to avoid the threat of legislative intervention, and ultimately, to secure their survival.

In addition to the overall state-municipal/regional economic agreements, the reform in 2007 also introduced new mandatory health agreements between municipalities and regions. The intention of these agreements is to promote coordination across municipal care services, primary care and hospital care. These agreements include a number of mandatory topics related to admission and discharge from hospitals, rehabilitation, prevention, psychiatric care and IT support systems. Formal targets for progress are agreed among the partners and also subject to national level monitoring.

The agreements are formalized at least once in each four-year election term for municipal and regional councils, and must be approved by the Danish Health and Medicines Authority. A structure of joint committees and working groups were set up to facilitate the negotiation and implementation of the agreements, and national guidelines, standards and indicators for monitoring progress have been developed.

The third generation of health agreements cover the period of 2015–2018. They include detailed agreements about a set of mandatory topics (prevention, admission and discharge procedures, training and rehabilitation, health IT and work processes). The detailed agreements must address the general issues of division of labour between regions and municipalities and different groups of health professionals, knowledge sharing and training, coordination of capacity, involvement of patients and relatives, equity, documentation, research, quality development and patient safety.

The framework of national and regional/municipal agreements backed by legislation (and threats of intervention) has created a flexible and relatively successful structure for coordination across governance levels. The historical tendency has been for the state to gradually take a stronger hand in the steering processes, although many policy details and implementation choices are still left to the regions and municipalities. The benefits of this system is to allow for flexible adjustments to regional and local conditions, while at the same time maintaining budget control and a high degree of equity across the decentralized units.

"The intention of these agreements is to promote coordination across municipal care services, primary care and hospital care."

Coordination of Care

Based on the health agreements and other national level initiatives, the regions and municipalities have implemented a number of coordination initiatives.

These include patient pathway programs (descriptions), and standards to support the regions and municipalities in developing more integrated services for chronic care patients. Pathway programs have been developed for a number of
chronic conditions, including heart conditions, diabetes II, chronic obstructive pulmonary disease (COPD), chronic back pain etc.

The regions and municipalities have also implemented organizational measures to promote integration of care. Examples include the use of outreach teams from hospitals doing follow-up visits in patients’ homes after discharge, training programs provided by the regions for municipal nursing and care staff, establishing municipal units located within hospitals to facilitate communication, particularly in regard to discharge, and the use of “GP practice coordinators” to facilitate communication.

More and more practices employ specialized nurses, and several municipalities and regions have provided financial support to set up multi-specialty facilities, commonly called “health houses.” The models vary across the country, but often include GPs, practicing specialists, physiotherapists and others. Medical homes are encouraged in the sense that GPs are intended to function as coordinators of care for patients and to develop a comprehensive view of their patients’ individual needs in terms of both prevention and care. This principle is commonly accepted and is supported by the general national-level agreements between GPs and the regions. GPs participate in various formal and informal network structures, and are included in the health service agreements made between the regions and the municipalities to facilitate cooperation and improve patient pathways; although, as in many other countries, there are concerns about the practical integration of GPs due to their workload and the incentive structures inherent in their status as private providers. Such issues are further complicated by the difficulties in recruiting new GPs in some areas of the country and by the fact that many older GPs still operate single practices. The regions have attempted to use the collective economic agreements with the GPs as a platform for increasing their leverage over the GPs in terms of coordination practices. This resulted in a major conflict in 2013.

The coordination efforts in the Danish health sector are supported by the development of national standards for ICT solutions, which enable providers to access electronic patient records and communicate electronically in regard to admissions and discharges. Prescriptions are also handled electronically and a national electronic “medical card” with prescription information is currently being implemented. Patients have access to their own health records via a national e-health portal called “Sundhed.dk.” The same platform is used for communication and as an entry point for health professionals to patient information, quality data, etc.

Many similar coordination initiatives have been taken in the Canadian provinces. However, the difficulty often lies in the detailed design and implementation. Experiences from other health systems, including Denmark, can provide inspiration for these processes.

References


Health System Regionalization – the New Zealand Experience

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ABSTRACT

New Zealand’s health system has many similarities with Canada, and also has long-standing experience with regionalization of healthcare services. Since 2001, the most important change has been the development of regional primary healthcare organizations funded according to population characteristics. This significant change has created the potential for a more integrated health system. However, barriers remain in realizing this potential. The key challenges include dealing with inter-organizational complexity and finding the right balance between hierarchical and collaborative relationships between the state and non-government providers. Although New Zealand governments have greater capacity to make changes to organizational and policy changes, professional interests retain considerable capacity to shape policy outcomes through implementation.

Introduction

New Zealand’s health system shares many characteristics with Canadian health systems. Healthcare is predominantly funded from taxation; both countries have political institutions of Westminster-style parliamentary democracy with comparatively clear channels of accountability for health policy and healthcare services. New Zealand’s type of health system architecture (fiscal and administrative delegation) reflects the most common Canadian model (Marchildon 2016). As such, New Zealand has also had considerable experience with regionalization (although this term is not used in New Zealand).
Notwithstanding these broad similarities, there are some important historical and institutional differences. Unlike Canada, primary medical in New Zealand is not (and never has been) fully funded by the government. New Zealand was one of the first countries to attempt universal coverage of health services in the late 1930s (Ashton 2013; Gauld 2013). However, in primary care, this ambition was successfully resisted by organized medicine, which fought to retain the right of family doctors to charge co-payments (Hay 1989). Even so, the public share of health spending is considerably higher in New Zealand (consistently around 80%) than in Canada, because pharmaceuticals and many non-medical services are predominantly publicly funded.

\[\text{New Zealand's Regionalization History}\]

On the face of it, New Zealand has followed a very similar trajectory to Canadian provinces. The period 1983–2001 has close parallels to the Canadian story from the 1990s. Prior to the 1980s, New Zealand’s health system consisted of hospitals that were publicly owned and funded, and governed by democratically-elected boards, whilst primary care services were provided by independent medical practitioners in small business. Over the course of the 1980s, there was organizational restructuring and consolidation from dozens of hospital boards to 14 Area Health Boards (AHBs), which were responsible for hospital and community-based health services, but not primary care.

In the “Big Bang” reforms of the early 1990s, the AHBs were abolished (including the structure of democratic representation) and replaced by a system of clear demarcation between four regional health authorities (RHAs) as purchasers, and providers (including hospitals and publicly funded community-based services) (Gauld 2001). In 1997, the four RHAs were merged into a single purchaser, the Health Funding Authority (HFA). Primary care arrangements were largely unaffected by these changes.

After a change of government, the HFA was abolished and a new system of District Health Boards (DHBs) was introduced in 2000. DHBs marked a return to administrative decentralization, integration of purchasing and provision and democratic representation. DHBs have a strong resemblance to the AHBs of the 1980s, but an important difference is that the 20 DHBs are required to plan and deliver services based on the needs of their population (Tenbensel et al. 2008). DHBs are accountable to the central government, which is clearly laid out in the New Zealand Public Health and Disability Act (2001). As of 2016, New Zealand’s
structure is more decentralized than most Canadian provinces. The rationale for this number of DHBs is primarily pragmatic, as it was close to the number of major hospitals, which provided the administrative homes of the new DHB organizations (Gauld 2001).

During the 1983–2001 period, the overarching rationales for structural change ranged from consolidation, rationalization and improved accountability (AHBs of the 1980s), efficiency, (purchaser–provider split of the 1990s) to population health, public participation and service integration (DHBs of the 2000s). In common with Canada, there has been limited research conducted on whether each round of restructuring led to desired improvements.

There is certainly no consensus among commentators that the current arrangement is optimal (Gauld 2009). Even so, structural reform has been off the agenda since the 2000 reforms, because both major political parties were cognizant of structural reform fatigue and electoral backlash. Attention has shifted to other policy instruments designed to encourage integration through the fostering of inter-organizational networks.

**Integrating Primary Care into Health System Governance**

Since 2001, the New Zealand regionalization story has taken quite a different turn. Governments have prioritized the integration of primary care into broader health system governance. The Primary Health Care Strategy (PHCS) introduced in 2001 was framed in terms of endemic problems of primary care access and inequality in New Zealand and the consequences for demand for hospital services (King 2001). These problems were largely attributable to the high level of patient co-payments in primary care. The PHCS was informed by Starfield’s work on the centrality of primary care (Starfield 1998) in health systems, the principles of Alma-Ata and its emphasis on primary healthcare as something much broader than family doctor services and a shifting of the locus of control from practitioners to the broader community.

The PHCS introduced a shift in the way the government funded its contribution to primary care from fee-for-service (FFS) reimbursement to capitation based on the characteristics of enrolled population. This new capitation model was more generously funded than the old FFS-based system (Mays and Cumming 2004). However, to receive the benefit of this increased funding, family physicians – known as general practitioners (GPs) in New Zealand – were required to become part of a new type of organization in primary care, known as Primary Health Organisations (PHOs). PHOs were established by the government as a type of non-profit organization, with a statutory set of minimum requirements for those who wanted to join.

PHOs were built on important developments in the organization of primary care in the 1990s. In response to the government’s introduction of competitive contracting models to the health sector, primary care doctors had formed new organizations, known as Independent Practitioner Associations (IPAs), that formed in order to collectively bid for funding from purchasers (RHAs) (McAvoy and Coster 2005). This environment also stimulated the development of third-sector primary care – non-profit organizations that served a low-income and high needs clientele (similar to Ontario’s Community Health Centres, but non-government owned), and the development of Māori health providers (Crampton et al. 2005).

In the 2002–2004 period of implementation of the PHCS, many of the 80 or so PHOs that formed were based on existing
organizations (IPAs, third sector and Māori providers), and the vast majority of GPs joined PHOs. Around 95% of the New Zealand population are enrolled in PHOs (Ministry of Health 2016a).

The relationship between government agencies (DHBs) and PHOs is primarily governed through the PHO Services Agreement – a contract for services, which is nationally consistent, but administered at the local level by DHBs. Through this mechanism, the primary care sector has contractual and, therefore, accountability relationships with government.

PHOs have been regarded as having the potential to be a driving force for the integration of primary health services with other parts of the health system (Gauld 2009). The government led by the National Party has sought to stimulate the development of alliances between public sector DHBs and non-government PHOs to plan, fund and deliver services at the local level. Governments have also attempted a number of mechanisms of encouraging collaboration in specific service areas, with mixed success (Mays 2013).

One key policy instrument for integration has been the extensive use of performance measures and targets. While some of these have been focused solely on hospitals, these are increasingly being used as ways to engineer greater collaboration between DHBs and PHOs. For example, in order to reach the target of 95% of all two-year-olds fully immunized by July 2012, significant cooperation was required between GPs, PHOs and DHBs, all of which were linked in a chain of accountability (Willing 2014). From July 2016, DHB and PHO alliances will be jointly responsible for performance against new “system level measures” (SLMs), including ambulatory-sensitive hospitalization for those 0–4 years old and rates of amenable mortality (New Zealand Ministry of Health 2016).

**Emergent Issues in New Zealand Health System Governance**

The changes since 2000 have embedded a system-wide focus on population health, even if DHBs and PHOs often have difficulty in developing specific initiatives aimed at improving population health outcomes and reducing inequities (Tenbensel et al. 2008). New Zealand’s relatively low proportion of sole-practice GPs (Royal New Zealand College of General Practitioners 2015) and high uptake of electronic health records (Protti and Bowden 2010) can be plausibly attributed in part to the changes outlined above, as PHOs enable and often take on themselves the aggregation of some primary care data management functions.

However, it is important to note some significant limitations and barriers to the effectiveness of this “regionalization of primary care,” and the integration of health-care services. Firstly, there has always been something of a mismatch between DHBs and PHOs in terms of scale and relationships. Back in 2008, Gauld argued that little policy consideration was given to the interaction between the DHBs and PHOs (Gauld 2008). Many PHOs traverse DHB boundaries, and many are not defined by geographic boundaries at all. There are some good reasons for this. Some PHOs are focused on specific populations. For example, one PHO is a federation of many Māori health providers, while another focuses on Pacific Island populations (Pasifika) across greater Auckland. It is also fairly easy (and common) for dissatisfied GPs to switch PHOs.
Although the number of PHOs had reduced to around 30 by 2012 (Cumming 2014), these different logics still create a complex inter-organizational environment. While DHBs and PHOs have contiguous boundaries and stable “one-to-one” relationships in some parts of the country, the complexity of inter-organizational relations increases in the larger urban centres, particularly New Zealand’s largest city, Auckland (Tenbensel et al. 2014).

This adds further complexity to a relationship between PHOs and DHBs that is characterized by a number of structural tensions. The first tension is between a population focus and a clinically-defined focus. Most PHOs, despite the aspirations of community-governed primary healthcare, are effectively controlled by GPs. Progress toward a population-based focus in PHOs has been slow, because the vast majority of capitated funding flows to GPs with little headroom left for initiatives to reduce barriers to access.

A second tension, familiar to Canadians, is between the prerogatives of the state as funder, and primary care providers still rooted in a private small-business model. DHBs have had difficulty enforcing their contractual authority in this environment—an example being the early failure of many GPs and PHOs to meet requirements for care on evenings and weekends without sanction (Controller and Auditor-General 2010). GPs have the additional “safety valve” of being able to raise co-payments—a right that is effectively enshrined and that has survived repeated governmental challenges (Croxson et al. 2009).

Against this backdrop, the third and perhaps most significant tension concerns the relative emphasis on hierarchical and collaborative relationships between DHBs and PHOs. Hierarchical, principal-agent relationships are hard-wired more generally into New Zealand public sector routines involving relations between government funders and non-government providers (Ryan 2011). The PHO Services Agreement and the system of targets attest to these strong lines of hierarchical accountability.

However, governments are also cognizant of the limitations of hierarchical approaches, partly due to the tacit power of health professionals to divert policy through implementation. The emphasis on collaboration and inter-organizational networks represents an attempt to develop a more integrated health system through softer, more “organic” means.

Some localities have clearly responded to this. The Canterbury district (based in the city of Christchurch) has been highlighted as an international exemplar of integration by the influential UK think tank, the King’s Fund (Timmins and Ham 2013). Innovative approaches include the pooling of DHB and PHO budgets regarding areas of service. The DHB has clearly stepped back from using a command-and-control approach and instead, emphasized its partnership with non-government-based primary care provision.

New Zealand’s experience over the past 15 years may be instructive for Canadian provinces, although there are always limits in what can be learnt (and possibly transferred) from one jurisdiction to another. This is pertinent at a time in which some Canadian provincial governments are considering the possibility of more regionalized primary care structures in order to foster a more integrated health system (Price et al. 2015).
The major challenge is working out how to blend hierarchical and collaborative styles of inter-organizational relationships (Tenbensel et al. 2011). The strengths and shortcomings of both approaches are readily apparent in New Zealand. Collaboration can produce innovative developments, but not – it appears – across the board, and not in a way that fundamentally changes the balance of power between state and profession. Hierarchical governance can and does change this balance, but is rarely effective at changing the hearts and minds of those delivering primary care services.

One important consideration is that some New Zealand developments are not easily transferrable to Canada, because of the different nature of government/interest group relationships in primary care. New Zealand governments have frequently been able to introduce changes in primary care without the prior agreement of medical interest groups (Ashton and Tenbensel 2010). Although these policies are usually transformed when implemented, governments can and do have considerable autonomy in devising new arrangements. Canadian provincial health policy, by contrast, is strongly corporatist – built on bilateral negotiating and bargaining relationships between provincial governments and medical associations. Arguably, the PHCS and the introduction of PHOs would not have survived a corporatist process of policy formulation and decision-making.

It is quite possible that key differences in the “accidental logics” (Tuohy 1999) of health system evolution in the two countries preclude Canadian governments from creating intermediary primary care organizations analogous to New Zealand’s PHOs. New Zealand’s developments were set in train by the outcome of the pivotal historical battle in 1940 over primary care co-payments, while Canadian dynamics are shaped by a different result of that battle in the 1960s. Canada’s system of “first-dollar coverage” entrenches the corporatist dynamic, whereas New Zealand’s has enhanced governmental autonomy in health system reform (Tenbensel 2008).

If this analysis is correct, then Canadian provinces may need to develop their own paths to health service and system integration, without the same capacity of New Zealand governments to set the agenda and drive change more unilaterally.

References


Transforming Regions into High-Performing Health Systems Toward the *Triple Aim of Better Health, Better Care and Better Value for Canadians*

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ABSTRACT

A study on the impact of regionalization on the Triple Aim of Better Health, Better Care and Better Value across Canada in 2015 identified major findings including: (a) with regard to the Triple Aim, the Canadian situation is better than before but variable and partial, and Canada continues to underperform compared with other industrialized countries, especially in primary healthcare where it matters most; (b) provinces are converging toward a two-level health system (provincial/regional); (c) optimal size of regions is probably around 350,000–500,000 population; d) citizen and physician engagement remains weak. A realistic and attainable vision for high-performing regional health systems is presented together with a way forward, including seven areas for improvement: 1. Manage the integrated regionalized health systems as results-driven health programs; 2. Strengthen wellness promotion, public health and intersectoral action for health; 3. Ensure timely access to personalized primary healthcare/family health and to proximity services; 4. Involve physicians in clinical governance and leadership, and partner with them in accountability for results including the required changes in physician remuneration; 5. Engage citizens in shaping their own health destiny and their health system; 6. Strengthen health information systems, accelerate the deployment of electronic health records and ensure their interoperability with health information systems; 7. Foster a culture of excellence and continuous quality improvement. We propose a turning point for Canada, from Paradigm Freeze to Paradigm Shift: from hospital-centric episodic care toward evidence-informed population-based primary and community care with modern family health teams, ensuring integrated and coordinated care along the continuum, especially for high users. We suggest goals and targets for 2020 and time-bound federal/provincial/regional working groups toward reaching the identified goals and targets and placing Canada on a rapid path toward the Triple Aim.
Regionalization constitutes de facto one of the main organizing strategies of health systems across provinces and territories in Canada, beyond the five founding principles of the Canada Health Act (public administration, comprehensiveness, universality, portability and accessibility) (Government of Canada 1985).

Over the past 20 years, there has been much experimentation with regionalization across Canadian provinces. The short-lived Canadian Observatory on Regionalization reviewed these natural experiments, highlighting certain elements of regionalization with regard to the performance of provincial health systems (Lewis and Kouri 2004).

Since 2004, however, as pointed out by Marchildon (2016) in his introductory essay of this issue, there has been little systematic evaluation of the impact of the regionalization of health in Canada. As one of the several contributions to this issue on regionalization, this paper attempts to address what have been the realizations – the impact – of regionalization across Canada toward the *Triple Aim of Better Health, Better Care and Better Value* (Institute for Healthcare Improvement 2016).

Interest in the healthcare services sector has recently shifted to managing for results and to continuous quality improvement. This is perhaps best exemplified by the high-performing healthcare organizations (accountable care organizations [ACOs]) in the US and the recent decision of the US Government to transform Medicare physician re-imbursement from fee-for-service to pay-for-performance (Kaiser Permanente 2015; Steinhauer and Pear 2015).

There have been recent announcements and undertakings of healthcare governance reform across Canada, such as the centralization of regional health authorities (RHAs) in Alberta, Nova Scotia and Prince Edward Island into one provincial health authority and Quebec’s recent shift to a two-level regional system as of April 1, 2015. These ongoing changes underpin the timeliness and importance of examining the impact of regionalization.

We conducted a study of regionalization across Canada in 2015. A detailed report is available (Bergevin et al. 2016). We will thus present here the salient features of the report, reflect on how one might implement in the near term the vision and way forward recommended and suggest what might be useful processes at federal, provincial/territorial and regional levels to reach specific time-bound health goals and targets, thus accelerating the progress toward the Triple Aim.

The regionalization of health services has progressed at different rates across provinces. Quebec was an early adopter, implementing regionalization together with universal health insurance in the early seventies. Ontario, on the other hand, has only recently pursued partial regionalization through its Local Health Integration Networks (LHINs).

Interest in the healthcare services sector has recently shifted to managing for results and to continuous quality improvement.
In addition to the interviews, we conducted a scoping review of the literature on regionalization in Canada over the past decade, as well as a rapid review of the characteristics of some high-performing health systems in other countries.

The study identified major findings. Based on these, the study team then developed a vision and a way forward with seven areas for improvement toward transforming regions into high-performing systems.

This study presents several strengths: the senior positions, expertise and experience of the interviewed health leaders together with their very high response rate (94%); the consistency of the findings across Canada; the convergence of the findings from the interviews with those from the literature; and the systematic validation of the findings by study participants when the draft report was circulated for validation and feedback.

Several factors made it difficult to tease out cause-and-effect relationships and to isolate the contribution of regionalization to overall improvements in health and healthcare: the lack of relevant healthcare performance data disaggregated at the regional level and the weakness of current information systems; the absence of formal evaluations of regionalization across Canada and in many cases the lack of meaningful annual reporting on performance; the multiple changes in the structure, functions and numbers of regions that have occurred since the beginning of regionalization across provinces, thus precluding an observation period sufficient to draw satisfactory conclusions; the fact that much of the literature is in the form of expert opinion and lacks quantitative evidence; and the lack of a true comparison group, although some would argue that Ontario, not having formally regionalized, could act as a comparator.

**Major Findings**

**Origins of modern district health systems/regionalization**

Following the Declaration of Alma-Ata on Primary Health Care in 1978, national governments sought to implement primary healthcare for their populations (World Health Organization 1978). This has led to a body of work on district health systems with ministries of health appointing district health management teams for each health district covering a population of around half a million (World Health Organization 2016). The emergence of “regions” across Canada generally corresponds to the WHO’s definition of “districts,” which is the usual international terminology for such health structures.

As Marchildon attests, all provinces except Ontario have undergone some degree of centralization of local health structures to RHAs, thus moving to a two-level system consisting of ministries of health and RHAs. This has been achieved by dissolving the boards of local health institutions and placing these institutions under the RHAs (Marchildon 2013). Over time, many provinces have also reduced the number of regions. A brief description of regional health systems in each province/territory is presented in the report.

**Regionalization in context**

Although life expectancy in Canada has increased from 78 to 81 years of age over the past 7 years (Organisation for Economic Cooperation and Development 2011) – it is now only 2 years behind that of Japan – “Canadian healthcare continues to be an underachiever” (Lewis 2015). Table 1 presents data for Canada, France (a high
performer) and the United States (our neighbour) on four important performance measures of the health system from a patient’s perspective. Nine percent of Canadian senior citizens spent over $2,000 out-of-pocket in the previous year compared to 0% in France. Only 45% could get a same- or next-day appointment with a doctor or nurse when needed (83% in France). Only 41% could access after-hours care (compared with 69% in France). And 39% of older Canadians had to use the emergency department in the past two years compared with only 15% in France (Osborn et al. 2014).

Table 1. Four health system performance measures from a patient’s perspective

<table>
<thead>
<tr>
<th>Issue</th>
<th>France</th>
<th>Canada</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spent $2,000 or more out-of-pocket in the past year</td>
<td>0%</td>
<td>9%</td>
<td>21%</td>
</tr>
<tr>
<td>Could get same- or next-day appointment with doctor or nurse when sick or needed care</td>
<td>83%</td>
<td>45%</td>
<td>57%</td>
</tr>
<tr>
<td>Access to after-hours care</td>
<td>69%</td>
<td>41%</td>
<td>55%</td>
</tr>
<tr>
<td>Emergency department use in the past two years</td>
<td>15%</td>
<td>39%</td>
<td>39%</td>
</tr>
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</table>

Source: Commonwealth Fund 2014. International Health Policy Survey of Older Adults in Eleven Countries (Osborn et al. 2014).

Under the Affordable Care Act (ACA), the United States is making rapid progress in reforming its health system. Population coverage is expanding and the growth in America’s healthcare spending is slowing. Increasingly, ACOs are emerging and offering more integrated and coordinated care at lower costs (The Economist 2015a, 2015b; Townsend 2013). High-performing health organizations such as Kaiser Permanente and Intermountain Healthcare provide many useful lessons for healthcare across Canada. Many of the senior leaders participating in the study raised the need to learn from such high-performing American organizations; key points included:

- access to client-centred care, clients taking charge of their own health destiny and health and wellness promotion;
- coordination and integration of services;
- support of electronic health records and integrated information systems, together with mobile applications for patients/clients;
- integration of physicians into the accountability of care with performance-based funding and relevant modes of remuneration; and
- inclusion of financial coverage of essential drugs, particularly in the ambulatory and home care settings.

Towards a two-level system

In recognition of the usefulness of regions, there has been a convergence of regionalization models across Canada with most provinces moving toward a two-level system, in which the ministry of health provides policy, financing and overall governance and oversight, and in which RHAs are responsible for regional governance (in line with provincial policies), management and service delivery for a given territory and population. Ontario’s system is structured between a two-level and a three-level system: the province has maintained local hospital boards, has a strong focus on access and quality and has instituted Local Health Integration Networks (LHIWs), which carry out certain integration and coordination functions but are not regions in the true sense of the word. The two-level system has proven very functional in several provinces, including British Columbia. As of April 1, 2015, Québec also moved to a two-level system; its 34 RHAs are called Centres intégrés de santé et de services sociaux (CISSS), nine of which are designated as university affiliated (CIUSSS).
Optimal size
Several study participants expressed the view that the size of regions is relevant to their functioning. A population size between 350,000 and 500,000 was deemed optimal, with travel times within the region not exceeding three to four hours. This is consistent with the approach recommended by the WHO and other multilateral agencies (Tarimo 1991; World Bank 1993). Different services are optimally organized and delivered on different scales, and thus for different population sizes: local for primary healthcare, regional for secondary care and provincial for tertiary care.

Better health, care and value: Better than before but variable and partial
There was a strong consensus among study participants that regionalization has contributed positively – albeit variably – to improving the health status of Canadians through an enhanced population health approach with better care, strengthened public health and an intersectoral approach to address the determinants of health. Regions act as integrators toward health improvement (Figure 1). However, the potential contribution of regionalization to better health has not been fully realized.

Regionalization has contributed to improved care through enhanced knowledge of the needs of communities and populations; an evidence-based approach to the provision of care; the development of needs-based regional service delivery plans; the regrouping of services for better quality, improved results and lower unit costs; and enhanced governance and managerial capacity. Our study has revealed a more integrated and coordinated approach to care with a better allocation of resources toward community, home and long-term care. Regional service delivery plans, specialist outreach and telehealth have additionally improved access to specialized services in the rural areas of regions. The results across Canada and within provinces are variable and there is still considerable room for improvement.

As regionalization has often been implemented in the context of budgetary constraints, it is not evident that regionalization per se has contributed to reducing costs. It can be said though that regionalization has contributed to enhancing the efficiency of the health-care system. Examples include: rational and evidence-based regional service delivery plans better responding to the needs of communities; the re-allocation of resources toward the community, ambulatory and long-term care;

Figure 1. Regions as integrators toward health improvement
the re-grouping of clinical services toward enhanced expertise, quality (reduced complications) and lower unit costs; the strengthening of primary healthcare including, in some cases, through the move away from fee-for-service physician remuneration; the reduction in management costs in some areas; and a long-term reduction in the pressure on emergency departments and hospitals arising, on the one hand, from stronger primary and community care, and on the other hand, from the improving health status of the population through better care, enhanced public health and intersectoral action. Here again, there is considerable room for improved efficiency while improving effectiveness and quality of care.

**Citizen engagement: Both pluses and minuses**

The impact of regionalization on citizen engagement was reported to be mixed and at times more negative than positive. On the positive side, the enhanced population health and intersectoral approaches have increased attention to the needs of communities and facilitated dialogue with elected municipal officials and community representatives. Specifically, efforts have been made to engage indigenous peoples in the governance of their health systems, particularly in British Columbia and Quebec. On the negative side, the dissolution of hundreds of local hospital, health centre and other institutional boards through their consolidation into one RHA has greatly diminished the involvement of citizens in the governance of their health institutions.

**Incomplete results-driven program approach, with unclear goals, targets and weak monitoring systems**

Despite health expenditures of the order of $200 billion in 2014 (> $6,000 per Canadian, 11% of GDP) (Canadian Institute for Health Information 2015), healthcare is often managed without the essential elements of a quality program approach: goals and objectives are often vague or absent, as are targets and baselines; monitoring systems are weak; theories of change and logical frameworks are incomplete; and emphasis on evidence-based interventions is variable.

**Engagement of physicians: Improving but variable and weak**

Although there has been important progress in the engagement of physicians as leaders, in clinical governance and in clinical networks, our study revealed very weak engagement of physician clinicians with regard to the health system, and regionalization in particular. Many study participants commented that the budget envelopes for physician services and for drugs – two very large components of health budgets and important drivers of the costs of the system – are not within the budget envelopes of RHAs. Most mentioned the need for far greater accountability of physicians for individual patient outcomes, service utilization and system performance; in this context, many referred to the high-performing healthcare systems, to the emerging results from ACOs in the United States and to examples from other countries. The modes of engagement, contracting and remuneration of physicians were recognized by study participants as one of the major obstacles to improving the performance of regional health systems across Canada.

**Patient-centred primary healthcare: Variable across Canada and weak relative to other countries**

There was consensus among the majority of study participants that access to timely, quality primary care is one of the major issues facing regional health systems across provinces and regionalization in particular. This was highlighted by the Commonwealth Fund...
2014 survey, which showed that only 45% of Canadian seniors could obtain a same- or next-day appointment with a doctor or nurse when needed, compared with 83% in France. Similarly, 39% of Canadian seniors used the emergency department in the past two years compared with only 15% in France (Table 1), evidence of failure of the health system to decrease the recourse to hospital-based care (Osborn et al. 2014; Tannenbaum 2014; Marshall 2015).

One of the goals of health systems should be to enable people to remain autonomous in their homes and communities. The access of Quebecers to family physicians has been particularly problematic; this problem has been identified as urgent and important by the provincial government and has given rise to major legislative reform and negotiations by the government in 2015. As these changes have yet to be fully implemented at the time of writing, the jury is still out as to their effectiveness.

“...Canada is at the forefront of the development of family medicine education.

Ontario has focused on access to primary healthcare with family health teams (FHTs), community health centres and more adapted modes of contracting and remunerating family physicians. Building on Ontario’s work to strengthen primary care, the Minister of Health and Long-Term Care in Ontario released *Patients First: Action Plan for Health Care* in February 2015 (Government of Ontario 2015). It is to be noted that 94% of Ontarians already have a primary care provider. Furthermore, for those 5% of patients with multiple and complex conditions, and who account for nearly two-thirds of healthcare costs, the government of Ontario has created Community Health Links to foster more coordinated and integrated care (Ministry of Health and Long-Term Care 2015). While there has been progress in Ontario, much remains to be done to ensure integrated and coordinated care, given that many patients still end up in the hospital emergency department needlessly.

Other provinces are also actively working to strengthen access to primary healthcare, the cornerstone and standard point of entry to healthcare across Canada (The Conference Board of Canada 2014).

Building on a strong history of general practice, Canada is at the forefront of the development of family medicine education. The College of Family Physicians of Canada (CFPC) promotes competencies through accredited residency programs and the Certification Examination in Family Medicine (CCFP). It has also promoted “Timely Access to Appointments in Family Practice: Same-Day/Advanced Access Scheduling” and “A Vision for Canada: Family Practice – the Patient’s Medical Home” (College of Family Physicians of Canada 2011, 2012) Passing the Certification Examination in Family Medicine has become a pre-requisite for family practice in some provinces. A number of provinces have begun moving – albeit slowly – toward FHTs and local health centres/family medicine centres (patients’ medical homes).

**Slow and variable progress on information systems and electronic health records**

Regional health executives have to lead and manage their RHAs on a daily basis much in the same way a pilot might have to fly a plane with a partial instrument panel, an infrequent emergency requiring urgent action. It was noted that there exist multiple health information systems, with major difficulties in exchanging relevant information between them. There is also an important variation in the rate of
implementation of electronic health records, and the lack of interoperability between these and information systems precludes any real-time management of the health system. Several participants placed the Canadian situation in sharp contrast with that of Kaiser Permanente in the US with fully interoperable integrated information systems, allowing for real-time management of individual patients and of the system, not to mention the mobile applications for patients who become partners in shaping their health destiny.

The frequent re-organization of the healthcare delivery architecture and of regional structures and functions within provinces
Several provincial and territorial governments have implemented changes to regional structures and functions every few years. While noting that some of these changes were necessary to improve function, these frequent changes – and poorly executed change management – have caused major disruptions to the system, taking precious time away from client-focused improvements in health service delivery in order to manage the changes. This has also prevented meaningful formal evaluations of regionalization. Several respondents appreciated the fact that most provinces have now moved to a two-level system and that provincial healthcare delivery systems are now reaching a stage of stability and maturity.

Insufficient clarity in roles and responsibilities of governments/ministries of health and of regional health authorities
Over the past decade, functions have been devolved to RHAs without a commensurate readjustment within ministries of health (absence of business process reengineering), often leading to duplications of function and to a tendency by ministries to micromanage regions. All study participants appreciated the need for oversight by an elected government. Most felt that the system performed best when the government remained at arm’s length from service delivery with clear communications between levels.

Inadequate financial coverage of essential drugs in ambulatory/home settings
RHAs are mandated to ensure the provision of client-centred care within communities and to promote the autonomy of clients, making the recourse to hospital care necessary only when other approaches have failed. The inadequate financial coverage of essential drugs in ambulatory care settings is a major roadblock to maintaining people in the community and to the optimal use of non-hospital services, thus contributing to the overutilization of hospital services and driving healthcare costs up. Reimbursing the cost of essential drugs in all settings would, in all likelihood, pay for itself, especially in the context of bulk negotiating and purchasing by provinces and territories. This would greatly facilitate the ability of RHAs to progress toward ambulatory, home and community care.

In summary, Canadians enjoy one of the highest life expectancies in the world. Regionalization has most likely contributed to this better health through better care, stronger public health and increasing intersectoral action to address the determinants of health. Regionalization has also most likely contributed to better value for money in health. However, we must not shy away from taking note of the serious problems confronting healthcare in Canada. Access to family physicians and to primary care is a major issue across Canada; wait times for specific procedures are very long in some provinces and go well beyond established benchmarks (Canadian Institute for Health Information 2014). Value for money could be improved considerably, especially when one compares Canada’s performance with that of other countries. Canada faces real
challenges in measuring its performance in health and acting on results despite the existence of excellent knowledge organizations and academic institutions.

Given the very solid base in Canada’s health system development – including the major contributions from regionalization – and the well-circumscribed nature of the issues facing healthcare across the provinces and territories, significant progress should be attainable within a few years by addressing a limited number of “system” issues.

We asked the study participants to identify what it might take to further enhance the performance of regions toward better health, better care and better value. These views have been summarized in a “way forward,” to identify a vision for regionalization and to posit seven areas for improvement.

**Way Forward**

**A vision for regionalized high-performing health systems in Canada**

Regions can provide the opportunity to achieve two aims: a high-performing health system and a territory to achieve population health improvement. By using a population health approach, regions can be powerful integrators of efforts to improve health and healthcare. On the care side, integration and coordination can best be achieved at the regional level, while simultaneously maintaining focus on specific local needs within the region.

A vision thus emerges for high-performing regionalized health systems and for territories where healthy public policies can be implemented. The realization of this vision rests on re-establishing and respecting the clarity of the respective roles and functions of provinces/territories and regions, and on ensuring the accountability of the health system’s various players (Figure 2).

The governance function of regions is particularly important to ensure an optimal adaptation of programs and resources to the specific needs of communities and characteristics of regions, as well as to meet the realistic expectations of key stakeholder groups. Regional governance is also necessary for the regions’ success in their efforts to engage and involve citizens and elected officials in health-related issues.

Two major *streams of work* are recommended:

1. A much greater focus on *population health* (including population-based planning and service delivery; and public health and intersectoral action to strengthen wellness and address the social determinants of health).
2. A renewed focus on the local level and proximity services with integrated and coordinated *primary healthcare* provided by highly accessible multidisciplinary family health teams/health centres.

Three *strategies* would underpin these areas of greater focus:

1. **Visionary executive leadership**, which advances a population health approach.
2. **Stronger physician leadership**, engagement and accountability for clinical and health system outcomes.
3. **Stronger patient, citizen and community engagement and leadership**.
Such an approach would be supported by a knowledge function through an enhanced evidence-based approach, information systems and an adaptive capacity to ensure continuous learning and quality improvement. Information would flow in real time through the system with interoperable electronic health records feeding into the population-based health information system. Physicians, managers and executives would be held accountable for results.

Financial coverage of essential drugs would be provided in ambulatory and home settings, thus further decreasing the recourse to hospital care.

Organizing services in this manner under one RHA enables the reallocation of resources between acute care, long-term care and primary care/home care/social services, thus ensuring that the system is well prepared to meet the care challenges of the future (Figure 3).

While such a vision may a priori appear unreachable or utopian, it is to be noted that high-performing healthcare organizations in the US, such as Kaiser Permanente and Intermountain and those in other countries, are approaching such a vision, at least on the care side. Furthermore, if one were to combine the best characteristics of health regions across Canada, one would likely achieve such a vision. Such a vision is, therefore, realistic in the near term for Canadian provinces and territories.

**Seven areas for improvement**

Stemming from the recommendations of the study participants and from further synthesis by the study team, the following are seven areas for improvement which, if implemented, would contribute importantly to achieving this vision and lead to major, rapid progress toward the Triple Aim. While these seven areas for improvement are each necessary for regions to achieve better health, better care and better value, several will require system changes beyond regionalization (Table 2).

<table>
<thead>
<tr>
<th>Table 2. Seven areas for improvement</th>
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<tbody>
<tr>
<td><strong>1</strong> Manage the integrated regionalized health systems as results-driven health programs, transforming them into high-performing health systems</td>
</tr>
<tr>
<td><strong>2</strong> Strengthen wellness promotion, public health and intersectoral action for health to better address the social determinants of health</td>
</tr>
<tr>
<td><strong>3</strong> Ensure timely access to personalized primary healthcare/family health teams (FHTs) and to proximity services</td>
</tr>
<tr>
<td><strong>4</strong> Involve physicians in clinical governance and leadership, partner with them in accountability for results and engage them in the required changes in physician contracting and remuneration</td>
</tr>
<tr>
<td><strong>5</strong> Engage citizens in shaping their own health destiny and their health system</td>
</tr>
<tr>
<td><strong>6</strong> Strengthen health information systems, accelerate the deployment of electronic health records and ensure their interoperability with health information systems</td>
</tr>
<tr>
<td><strong>7</strong> Foster a culture of excellence, learning, innovation and research and encourage adaptive capacity towards continuous quality improvement</td>
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*Figure 3. Regions as integrators toward health improvement*
1. Manage the integrated, regionalized health systems as results-driven health programs, transforming them into high-performing health systems

In order to achieve high performance, regionalized health systems will need to be managed as results-driven health programs with clear goals, targets, baselines, benchmarks and milestones, as well as a strong-performance monitoring system with clear indicators and support from solid real-time information systems.

These systems should be characterized by robust accountabilities and metrics: physicians, managers and executives of RHAs should be held accountable for the health outcomes, utilization and value for money of their respective clienteles/populations.

Furthermore, regions should have multi-year strategic/business plans that include regional service delivery plans (with medical staffing plans), public health and intersectoral action. They should also be held accountable for their implementation and monitoring of results.

2. Strengthen wellness promotion, public health and intersectoral action for health to better address the social determinants of health

Every opportunity to engage patients and citizens in shaping their own health destiny should be taken. This should be achieved in partnership with health professionals and by encouraging population health strategies and the adoption of healthy behaviours, preventing to the greatest extent possible chronic conditions and injuries, and promoting healthy living and aging.

Population and public health should be strengthened at regional, provincial and federal levels, while differentiating which actions are best conducted locally (and often in partnership with municipalities and community groups), and those which are better conducted regionally, provincially or federally. Intersectoral action for health at local, municipal, regional, provincial and federal levels should simultaneously be strengthened using approaches that are best suited for the issues at hand and through the engagement of elected officials, community representatives and ordinary citizens.

Recurrent funding for this investment in wellness will need to be increased. In the spirit of Better Value of the Triple Aim and the recurrent cost-savings approach of the report, these additional costs should be covered by the highly effective and revenue-generating interventions of increased tobacco and new sugary drink taxation.

3. Ensure timely access to personalized primary healthcare/FHTs and to proximity services

Building on Canada’s strong tradition and excellence in family medicine education, every Canadian should be ensured access to timely, appropriate, comprehensive and high quality primary care. We should continue to encourage interprofessional family practice teams comprising nurse practitioners, family physicians and other health professionals with a responsive appointment system, after-hours coverage, home care/visits as needed and coordinated and integrated care, especially for those who need it most (Spitzer et al. 1974). These FHTs should ensure continuity of care and foster attachment.

Learning from high-performing organizations and from other countries, funding for these family health teams/health centres should be results-based and not simply fee-for-service (Atun 2015; Burwell 2015; Marshall 2015). Regions will need to re-focus their attention to the local level by way of proximity services (soins de proximité), enhanced citizen engagement and local intersectoral action in collaboration with municipalities and community groups.
4. Involve physicians in clinical governance and leadership, partner with them in accountability for results and engage them in the required changes in physician contracting and remuneration

Building on recent progress in clinical governance, physicians should be much more involved as leads for clinical services and be held accountable for the results of the clinical services they lead. Clinical governance, in this case, is optimally achieved by physician leads/co-leads, who display strong leadership and who foster motivation and teamwork. Strengthening the quality of care and clinical excellence would also require the further development of strategic clinical networks that connect individual clinical services within and across regions.

Beyond that, individual clinicians should be held accountable for their patients’ outcomes and co-accountable for the performance of the health system. Modalities of contracting and remuneration will need to reflect this new reality. While provincial medical associations have resisted such approaches in the past, there is an evolution toward remuneration models other than simply fee-for-service, such as capitation as part of blended remuneration. It is to be noted that physicians in organizations, such as Kaiser Permanente, and in other jurisdictions achieve a high level of professional satisfaction and remuneration commensurate with their expertise and workload under performance-based funding.

Remuneration should be adapted to the diversity of functions: patient care including on-call coverage, management, teaching and research. One is reminded of the wisdom of Sidney Lee’s *The Three-Layered Cake*, which describes a remuneration scheme consisting of three layers: basic compensation, personal incentives and system incentives (Lee SS 1974, 1975). We would do well to learn from experiences across provinces and from recent changes in the reimbursement system for Medicare in the US and other countries (Bras and Duhamel 2008; Pear 2015).

In this context, a strong argument can be made to regionalize budget envelopes for the remuneration of physicians, whether it is for family physicians operating within family health teams/centres, for family practice and specialist services in hospitals or for other specialized ambulatory services. Integrating physicians within regionalized structures and functions in this manner will ensure that integration reflects the notion of the production process within an organization—a key, but often neglected management principle (Coase 1937).

5. Engage citizens in shaping their own health destiny and their health system

As Eric Topol suggests in his book *The Patient Will See You Now*, we need to ensure that citizens are much more engaged in shaping their own health destiny in partnership with their health professional (Topol 2015). Their engagement in the governance of their local and regional health system should likewise be fostered; they should also have the opportunity to participate in local citizen/patient committees linked with their community health teams/centres, as well as in intersectoral action for wellness and the prevention of non-communicable diseases and injuries. RHAs should also further strengthen patient advocacy and representation mechanisms at all levels of the system and further strengthen the dialogue with elected municipal officials and other community representatives.

6. Strengthen health information systems, accelerate the deployment of electronic health records and ensure their interoperability with health information systems

In order to provide client-centred, integrated and coordinated care and improve the performance of the health system, electronic health
records that feed into a real-time population-based health information system should be fully deployed, as is currently being done in high-performing healthcare organizations, with the principle of one person – one record (electronic medical record, health information system including financial data).

While this will require additional funding during the deployment and upgrade phase, such a system should greatly improve the efficiency of health service delivery through clinical analytics, prevent duplication and unnecessary procedures, avert potentially dangerous drug interactions and support the maintenance at home and in the community of individuals, who might otherwise end up in the emergency room and require hospitalization. All this should lead to recurrent cost savings, which should ultimately recover the deployment and upgrade costs of a fully integrated electronic health records and information system.

7. Foster a culture of excellence, learning, innovation and research and encourage adaptive capacity towards continuous quality improvement

In order to foster excellence, the passion for care needs to be rekindled by involving and motivating health professionals and their professional bodies, and by fostering an approach of continuous quality improvement in all health service delivery and public health institutions. This will require effective leadership of ministries of health, RHAs and other health organizations, as well as nurturing a partnership with physicians in the context of enhanced accountability for results for their patients and the populations they serve. Accreditation mechanisms and continuous quality improvement (CQI) strategies can contribute significantly to this effort. Provincial ministries of health should hold regions accountable for these results, including use of performance-based systems, proportion of health facilities and FHTs participating in collaborative CQI and accredited.

As knowledge is global, we should learn from the best of each system, both within Canada and internationally, and address the priority issues and areas for improvement discussed here. It will be important to emphasize increased interregional and interprovincial learning and the implementation of innovations and best practices with rigorous evaluations and evidence of improved effectiveness and efficiency. The recently published Naylor Report emphasizes the need for meaningful change, the importance of innovation toward a better performing health system and the importance of well-documented experimentation (Government of Canada 2015).

We should strengthen research programs that can contribute to improving the Canadian health systems. This can be achieved through a coordinated effort of the Canadian Institutes of Health Research (CIHR), provincial research funds, academia and provincial ministries of health/regions with a view to addressing the issues and areas for improvement presented. We will need greater emphasis on and more investment in implementation research closer to the delivery of services, as well as in population health interventions, fostering a culture of learning systems.

Furthermore, high-performing ACOs in the United States and elsewhere should be studied with the specific objective of learning what could realistically be applied to the Canadian healthcare context to bring about major improvements.

As knowledge is global, we should learn from the best of each system, both within Canada and internationally ...
Towards a Paradigm Shift

The recent book *Paradigm Freeze: Why It Is So Hard to Reform Health-Care Policy in Canada* leaves us with the impression that change in Canada’s healthcare will be very difficult (Lazar et al. 2013).

This study provides a different conclusion. The health of Canadians is one of the best in the world, and Canadian provinces and territories are each pursuing a path to improve their healthcare systems. The vision and areas for improvement identified in this paper are straightforward and could lead to significant progress toward better health, better care and better value in only a few years, at modest one-time costs recuperated with recurrent cost savings. Money, therefore, should not be a roadblock to change.

Furthermore, there is a growing energy for change. Among others, three recent events demonstrate this phenomenon: a Policy Forum on Advancing Quality Through Regional Clinical Governance held in Toronto in March 2016 and, in May 2016, a Symposium des leaders en santé organized by the Order of Nurses of Quebec and a McGill Primary Care Policy Symposium (CAHSPR et al. 2016; McGill University Department of Family Medicine 2016; Order of Nurses of Quebec 2016). These three recent events each brought together several hundred participants and shared the theme of clinical excellence and quality through integrated, coordinated care along patient trajectories, with strong executive, professional and patient engagement.

We are proposing a turning point for Canada, from Paradigm Freeze to Paradigm Shift: from hospital-centric, episodic care toward evidence-informed population-based primary and community care delivered and coordinated by FHTs (including those within community health centres as the case may be) (College of Family Physicians of Canada 2011, 2012; McGill University Department of Family Medicine 2016). These FHTs should ensure integrated care trajectories along the continuum with strong patient and family engagement, together with the relevant specialty programs, and social and community services when needed.

Such an approach, characterized by realistic and practical clinical excellence, should contribute to maintaining people at home and in their community and decrease the recourse to emergency department and to hospital use (Reid RJ 2013) and, in the long run, lead to costs savings. It should better prepare us to meet the needs of Canada’s aging population.

Realizing all at once the vision and way forward with its seven areas for improvement may appear daunting; focusing on primary healthcare is likely to be a good entry point to begin realizing this vision and to bring high returns in a few years.

How could we stimulate the change required for this paradigm shift?

First, to focus the mind, we might wish to set some goals and targets for the near term. The following goals and targets are presented as examples, to begin a conversation, and are not meant to be prescriptive or exhaustive.

We suggest, to begin a discussion, the following goals and internationally comparable targets for December 2020:

1. Ensure that >90% of Canadians have access to a FHT
   - As measured by FHT rosters
   - Could get same- or next-day appointment with doctor or nurse when sick or needed care
   - Access to after-hours care
2. Ensure coordinated and integrated care for >90% of high users
   • Decrease in emergency department use
   • Decrease in rates of hospital admissions
   • Decrease in median number of prescription drugs

**A pluralist approach to continuous quality improvement supported by shared goals and metrics**

We need to consider evidence-informed approaches to management of change, continuous quality improvement, diffusion of innovation and scale-up, especially in the context of organizations with highly-educated self-driven professionals for whom professional satisfaction is highly valued.

While some would argue for a bottom-up approach and others for a top-down approach to change management, success may lie in an approach that fosters working together with common goals and practical, measurable, achievable and realistic targets.

It may well be worth remembering the wisdom of the 1970 Quebec Castonguay-Nepveu Commission, which recommended a pluralist approach to primary healthcare for Quebec; local health centres could stem from, but not be limited to, a public corporation originating from a group of citizens joined by a health team; a public corporation developed under the initiative of a group of health professionals with public representation; a private corporation composed of health professionals with consultative community input (Gouvernement du Québec 1970). Ontario, with its different models of FHTs and its community health centres, is a good example of an evolving pluralist approach with a focus on collaborative continuous quality improvement with support from Health Quality Ontario (Ontario College of Family Physicians 2015a, 2015b).

At the recent McGill Primary Care Policy Symposium, Michel Clair, Chair of the 2000 Clair Commission, which recommended Family Medicine Groups for Quebec (Groupes de médecine familiale or GMF) put forward the idea of GMF 3.0. Similarly, Robert Reid presented the concept of Medical Home v 2.0 (Gouvernement du Québec 2000; McGill University Department of Family Medicine 2016). Can we work further to better refine these concepts with the best evidence on the essential elements of an optimal FHT? Based on these, should we develop a formal process of accreditation of FHTs much as we do for other healthcare institutions?

**Addressing the management of change simultaneously at the three levels of the system**

In order to effect a paradigm shift and the required rapid change, significant momentum needs to be garnered by executive, professional and patient champions at the three levels of the system: federal, provincial/territorial and regional.

Following Canada’s federal election in October 2015 and the election of a new Liberal government, the Prime Minister of Canada instructed the Minister of Health through her *Minister of Health Mandate Letter* to:

> “Engage provinces and territories in the development of a new multi-year Health Accord. This accord should include a long-term funding agreement …”
> (Trudeau 2015)

A renewed health accord is a unique opportunity to strive for the Triple Aim and to be innovation-driven and performance-based. Canada’s new federal Minister of Health has already indicated that, throughout her career, she has been led by the *Triple Aim of Better Health, Better Care and Better Value* and has expressed a desire to advance these goals for all Canadians (Philpott 2016).
We propose a small, time-bound federal working group/task force composed of, at minimum, the federal Ministry of Health, the CFPC, the Canadian Medical Association (CMA), the Canadian Nurses Association (CNA) and academic and patient representatives. These various members should commit to this paradigm shift and consider how best to support this pan-Canadian change, in the context of the development of the new accord.

Each province/territory might also wish to consider creating a similar time-bound working group composed of the provincial/territorial Ministry of Health, RHAs and provincial/territorial chapters of the CFPC, CMA, CNA, faculties of health sciences, patient representatives and other key stakeholders with a view to rapidly addressing the above goals and targets.

Within regions, RHAs might set up time-bound working groups with FHTs and CHCs, patient representatives, representatives of medical specialties most involved in care trajectories, public health to foster a population-based approach, long-term facilities and other relevant key stakeholders. These working groups would rapidly address the above goals and targets, keeping in mind both population and geographic coverage, as well as addressing the needs of aboriginal communities and other groups with specific needs.

RHAs will need to be given the tools by provincial ministries of health to exercise greater leadership and governance as related to primary healthcare: a clear mandate, the budget envelopes including for physician payment and full responsibility for management and oversight. Communication between levels would foster the rapid resolution of bottlenecks. Strong clinical analytics would help measure progress. Knowledge from good, well-measured practices would be disseminated for everyone’s benefit.

While this paper attempts to address the Triple Aim of Better Health, Better Care and Better Value for Canadians, one should not forget the fourth component of what is now referred to as the Quadruple Aim: professional satisfaction and happiness in the workplace. Until recently, Canada may not have paid sufficient attention to this fundamental component (Sikka R 2015). Improving organizations and systems that foster professional satisfaction and happiness, in part by reaching practical clinical excellence, will benefit both health professionals and the people they serve.

In order to succeed with this paradigm shift and its related management of change, we will need executive, professional and patient champions with strong leadership skills. How can we harness the leadership and identify the champions in each province and territory to transform our regions into high-performing health systems toward the Triple Aim of Better Health, Better Care and Better Value for Canadians? Can we envision Canada becoming a world leader in primary healthcare? We believe that we must seize the moment.

Acknowledgements
This study would not have been possible without the outstanding participation of the 30 senior health leaders from across Canada. A sincere thank you to each of them for taking time out of their extremely busy schedule and for their effort. Deep appreciation for their thoughtfulness in analyzing the major issues confronting health and healthcare across Canada, in contributing to identifying potential areas for improvement and in reviewing the draft report to validate the robustness of the findings.

Sincere thanks to the staff of the Canadian Foundation for Healthcare Improvement and, in particular, to Colby Williams for her tremendous coordination and follow-up and Diane Hull for all her support.

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Regionalization as One Manifestation of the Pursuit of the Holy Grail

COMMENTARY

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ABSTRACT
Regionalization has strengths and weaknesses. The balance of the two will vary over time, differing in different contexts and with different implementations. Alberta’s implementation of a centralized structure had some strengths: economies of scale and expertise; opportunities for province-wide learning; internalization of geographic politics; and improved geographic equity. It also had weaknesses: diseconomies of scale, remoteness from communities and politicization.

In any implementation of regionalization, policy makers should attempt to realize the benefits of alternative paths not travelled and minimise the weaknesses of the chosen structure.

As Marchildon (2016) notes, health system reform has multiple objectives, some overt, some less so. Typically, regionalization has two interrelated components:

1. aggregation of the governance of disparate health sector entities into an organization defined geographically; and
2. delegation of responsibility to the geographic entity.

The hope of regionalization was that it would achieve allocative (or social) efficiency by facilitating the right mix of investments across various models of care (e.g., hospitals vs residential aged care). That this hope has not been realized has not stopped advocates of regionalization from continuing to spruik its (supposed) merits. It was also hoped to improve continuity of care – a strategy also now being pursued by other means, e.g., US
Accountable Care Organizations (ACOs) and Ontario’s Quality-Based Procedures (QBPs). Alberta was an early adopter of the regionalization project, consolidating 195 organizations into 20 in 1994, down to 12 in 2003 and finally, 1 in 2009 (see Table 1).

As with other provinces, none of these models involved complete regionalization – responsibility for design or implementation of fee-for-service payments to physicians was not assigned to regional authorities under any model.

Most recently, Alberta was a front-runner in the single authority model – the first province that has a regional health authority (RHA), which covers the whole province (Duckett 2010). The creation of the authority was hasty, with the justification for the change lost in the entrails of the politics of the day (Donaldson 2010). What can be observed today are some of the strengths and weaknesses of this approach.

**Strengths of a Single Authority**

There are four main (potential) strengths of a single authority compared to multiple regional authorities, at least as implemented in Alberta: economies of scale and expertise; opportunities for province-wide learning; internalization of geographic politics; and improved geographic equity.

Aggregation of multiple authorities into a single authority allows consolidation of back office functions. In Alberta, each previous authority had a governance infrastructure of boards (members were paid), chief executive and corporate governance support. Larger RHAs had a larger infrastructure. Chief executive officers were generously remunerated. Each of the executives of three of the authorities – Capital, Calgary and Cancer Board – merged into Alberta Health Services (AHS) had a total remuneration greater than that of the chief executive of the combined authority (Duckett 2011). The Board office of AHS had the same staffing (both in terms of number of staff and people) as that of the previous Calgary RHA.

Economies of scale went beyond the immediate governance roles. AHS back office functions were about half to two-thirds the size of the combined human resource, finance and information technology functions of the previous combined authorities.

Another area where amalgamation allowed achievement of scale economies was in procurement. Significant savings were achieved from standardization, volume discounts and elimination of questionable procurement practices. An example of the latter was one prosthesis supplier made a regular modest donation to a surgical research fund, which appeared to affect the ability of the predecessor health authority to conduct a transparent evaluation of products. Centralization of purchasing resulted in the loss of donation, but this was more than offset by better prices.

A second and related benefit was sharing of expertise from the two larger previous authorities, Capital and Calgary especially. Those authorities had a number of corporate staff who had developed expertise in their areas of responsibility (e.g., food services and laboratory medicine were some examples). Some of the smaller authorities had also developed expertise in aspects of health management (e.g., Chinook in using Lean Techniques).

Following the merger, this expertise became available across the province, resulting either in savings or improved services or both. The merger also allowed standardization of accounting practices and definitions, which had precluded effective interregional comparisons in the past.
Regionalization as One Manifestation of the Pursuit of the Holy Grail

Table 1. Alberta’s shrinking reporting points 1988+

<table>
<thead>
<tr>
<th>Era</th>
<th>Ministries</th>
<th>Hospital boards</th>
<th>Long-term care boards</th>
<th>Public health boards</th>
<th>Central health service boards</th>
<th>Regional health authorities</th>
<th>Total (not including ministries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-1988</td>
<td>2: Hospitals and Medical Care and Community Health</td>
<td>128</td>
<td>40</td>
<td>25</td>
<td>2: Cancer and Mental Health</td>
<td>0</td>
<td>195</td>
</tr>
<tr>
<td>1994–2003</td>
<td>Alberta Health and Wellness</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3: Cancer, Mental Health and Alcohol and Drug Abuse</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>2003–2008</td>
<td>Alberta Health and Wellness</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>2008–</td>
<td>Alberta Health and Wellness</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1: Alberta Health Services</td>
<td>1</td>
</tr>
</tbody>
</table>

The initial AHS formal structure incorporated many province-wide leadership roles, including having major hospitals in Edmonton and Calgary accountable to the same executives, and all regional hospitals (Red Deer, Lethbridge, etc.) accountable to the same person. This structure facilitated internal benchmarking of previously separately governed services. A single authority also enabled consistent implementation of best practices, including improving patient flow to reduce long waits in emergency departments (Duckett and Nijssen-Jordan 2012).

As a province, Alberta has been characterized and cursed with a high degree of intraprovincial rivalry between Edmonton and Calgary. Each previous health authority saw its responsibility as pursuing a medical arms race with its rival(s), with the result health system planning was dominated by political calculations rather than (relatively) technocratic assessment of population health needs. Partly as a result of this unhealthy competition, Alberta was a relatively expensive province in terms of health expenditure per head of population (Duckett et al. 2012, Duckett 2015).

Creation of AHS internalized these tensions and allowed a new priority-setting process, which ranked all policy proposals against each other. The initial formal structure of AHS gave each member of the executive responsibility for both line management and province-wide policy or operations. This strengthened mutual accountability and reduced parochial pleas.

Intraprovincial rivalry continued, of course, but in some cases was able to be harnessed for good. For example, following media advocacy about the need for additional radiation oncology capacity (linear accelerators) in Calgary, I requested information on the current efficiency of existing machines in Calgary and Edmonton (treatments per machine per annum). This comparative information had not been previously collected.

There was a significant difference between the two cities in radiation oncology efficiency with Calgary being less efficient than Edmonton. A “Lean” process was initiated in Calgary, which significantly improved efficiency and generated additional treatment capacity. Not to be outdone, a similar process...
was also initiated in Edmonton, which led to further efficiency improvements there, creating a virtuous improvement cycle.

Different predecessor authorities in Alberta pursued different policies and approaches in many areas; naturally so, since “regional responsiveness” is claimed as one of the strengths of authorities covering smaller geographic areas. The inevitable consequence was differential access to services. In Alberta, this resulted in quite different levels of provision (and hence access to) residential aged care and home care. In two parts of the province, some mental health inpatient services were still provided in isolated, stand-alone facilities – a model not consistent with contemporary service system design internationally.

Creation of AHS allowed “best practice” experience to be implemented across the province (with mental health reform in Edmonton being a standout example of failed policy implementation). Best practice roll-out involved developing standardized measurement tools and access metrics, implementing province-wide funding formulae, and favouring poor-access areas in a budget priority setting.

Weaknesses of a Single Authority

There were three main weaknesses of the Alberta model of implementation of a single province-wide authority compared to multiple regional authorities: diseconomies of scale, remoteness from communities and politicization.

Although the creation of a single province-wide authority allows economies of scale, it also creates the potential for diseconomies of scale. AHS is a very large organization, now with more than 100,000 employees – it is probably the fifth-largest employer in Canada and more than three times the size of any other health service.

An organization of this size inevitably involves multiple layers of reporting with all the disadvantages that entails. The first full year of AHS was plagued by addressing significant budget challenges, which involved very tight budget control. In the second full year, with a better budget outcome, significant changes to formal delegations were approved. However, the consistency with which these were implemented varied across the organization with some middle managers requiring “consultation” on decisions when formal delegations allocated decision rights further down the chain. Centralization also created delays in decision-making.

A second disadvantage of centralization is the removal of top decision-makers from many local communities. Although the AHS Board met at least annually in each of the seven major cities in the province, and senior leaders (including myself) regularly visited towns and cities across the province, an annual foray, or even regular visits, does not provide the same access for local elites to the Board and executives as local residence.

RHAs covering smaller geographic areas had a range of informal mechanisms for tapping into the views of local communities. This created a perception (often realized) of local responsiveness. In contrast, AHS took almost two years to establish any form of local engagement (through community advisory committees), resulting in a real loss of understanding of local issues and priorities.

The structure of AHS, with many local functions (e.g., catering and security) reporting through province-wide services also disrupted local coordination. Furthermore, province-wide priorities to reduce expenditure and improve efficiency often conflicted with local employment goals or supporting local suppliers.

Together, this created the impression of AHS as an out-of-touch lumbering giant disregarding local needs and aspirations.
A final weakness of a single consolidated authority is the enhanced potential for politicization, particularly in a province characterized by clientelism (Duckett 2015). Where multiple (competing) regional authorities exist, there is a clear and obvious separation of the regional authority from government, even though the authority may have very strong political links to the governing party. With only one authority in the province, there is the risk that the authority will lose the perception of independence. This risk is particularly strong with a micro-managing minister. This then constrains the autonomy of the organization and increases the risk of political decision-making.

The Balance of Strengths and Weaknesses

Johnson (1996) identified that critical decisions often have no right answer – that each choice, in this case, a single authority or multiple – has strengths and weaknesses. His solution (“polarity management”) was to make the choice, having first identified those strengths and weaknesses, and then take action to minimize the expected weaknesses of the chosen path and try to obtain some of the strengths of the alternate path. For example, the community involvement weakness of a centralized organization could, in part, be mitigated through advisory committees. The economies of scale strength of a centralized organization could potentially be available to multiple separate authorities through agreed centralized purchasing.

Schön (1971) identified polarities in organization design face both centripetal and centrifugal forces and that, in some period, one form (centralization vs decentralization) is emphasised over the other, with organizational design often swinging like a pendulum from centralized to decentralized and back again. What is interesting about the Alberta experience so far is that, despite a change in government – a once in a generation experience in the province – AHS has not been unwound, suggesting that the new administration has recognized the benefits of the consolidation and is seeking to mitigate the weaknesses through strategies other than starting afresh. This, in turn, suggests that other provinces may be able to watch the Alberta experience to assess the benefits of consolidation after the turbulent implementation phase has passed and at least one organizational leader has remained in place for a consolidating period.

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The Politics of Regionalization

COMMENTARY

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ABSTRACT

Regardless of their policy outcomes, strategies of regionalization are prevalent because they are politically useful. They permit governments to be seen addressing serious systemic problems in the healthcare system without fundamentally upsetting the face-to-face relationship between physicians and patients. They shift the responsibility for unpopular policies, including the consolidation of services, away from provincial governments. They can be part of a larger process of decentralizing power that is undertaken for larger, non-health-related reasons. They can also serve as a strategy of disruption that destabilizes the bases of influence enjoyed by specific stakeholder groups. For epistemological reasons, it is difficult to determine with any certainty what the specific outcomes of regionalization are. Thus, to mitigate the utilization of regionalization for politically advantageous reasons, it is useful not only to catalogue the outcomes of policies of regionalization, but also to identify whose interests are furthered, and whose are hindered, within a strategy of regionalization.

Why is it, in this age of evidence-based medicine, that so many jurisdictions over the past two decades have regionalized (or consolidated) their healthcare systems, despite the considerable lack of evidence regarding the effectiveness of these policies? One answer is: because strategies of regionalization (or consolidation) are politically useful regardless of their policy outcomes.

Implementing (or modifying) regional structures of governance can, in the first place, present a way for governments to be seen responding to public pressure to address serious systemic difficulties within healthcare,
without alienating those using healthcare services. Healthcare reforms that occur at the point of contact between healthcare providers and patients tend, as Lazar et al. (2013) have noted, to be highly unpopular. By contrast, reforms that focus upon the higher echelons of healthcare administration are more invisible to healthcare consumers and are tolerated much more comfortably. The political rhetoric of regionalization is simple and intuitively plausible even without a solid body of empirical evidence to support it. Because of this, it is also well-suited for incorporation into electoral campaigns. This is important, as electoral campaigns serve as a process of legitimation supporting the reform process once a party is in office (ibid.). The concept of regionalization is inchoate enough to endorse a wide variety of outcomes: it is quite coherent, for example, either to argue that decentralizing administrative authority can “result in effective and efficient use of existing capital,” or to hold that centralizing administrative authority can produce a less fragmented and, therefore, more efficient healthcare system (as Nova Scotia did, respectively, in 1989 and 2015).

Some administrations … were able to survive the widespread closure of rural hospitals; others were not.

The implementation of several regionalized healthcare systems in Canada occurred during the early- to mid-1990s – a period of economic contraction in which unpopular decisions to consolidate healthcare services had to be made. Acutely aware both that a plethora of rural hospitals was hugely inefficient, and that rural constituencies were quite protective of these hospitals, for example, provincial governments shifted the burden of determining precisely how cost savings were to be made to regional health authorities (RHAs). Some administrations, such as Ralph Klein’s Conservative government in Alberta, were able to survive the widespread closure of rural hospitals; others were not. Employing RHAs to deflect public discontent from provincial governments, however, conflicted with the aspiration expressed in reports tabled in some provinces (including British Columbia, Saskatchewan and Nova Scotia) that regionalization could be a concrete means of accommodating a broader base of citizen engagement in governance and policy making (Bickerton 1999). As a policy construct informed by New Public Management, the underlying principle of regionalization was that administrative decision-making in routine policy areas was more effectively performed at levels closer to the community (balanced by departments of health retaining responsibility for the overarching coordination of policy design and implementation). The main instrument of citizen engagement was to be elected and accountable community health boards, and some reports even saw these community health boards as the focal point of a regionalized system, with RHAs merely acting as a coordinating mechanism between active community boards and the provincial health department (Nova Scotia 1994). But regionalization as an instrument of democratization was an idea that never came to fruition in any jurisdiction. With healthcare budgets constituting close to half of public sector spending in many provinces, governments were loath to sanction decision-making mechanisms that could potentially expand demand rather than contain it. The emphasis upon regional decision-making bodies became less about encouraging the broad participation of local stakeholders and more about requiring health authorities to make politically unpopular decisions in order to remain within strictly defined budgets.
Healthcare systems can also adopt regional structures incidentally, as the answer to a political problem that has nothing at all to do with healthcare. In some states, such as Spain (in 1978), Brazil (in 1988) and Russia (in 1993), political decentralization was the response to a history of authoritarian rule. The reorganization of healthcare in these states was not a considered re-thinking of healthcare governance per se, but rather part of a larger move toward the institutionalization of the dispersal of power on a regional basis (Chubarova and Grigorieva 2015; Lobato and Senna 2015; Pérez Durán 2015). The historical context of these states is especially important, because it imposes potential limitations on subsequent reforms. States that have adopted regional governance mechanisms due to a suspicion of the un-salutary aspects of centralized power will, like Spain, be much more wary of attempting to reconsolidate structures of healthcare governance at a national level than states without similar experiences.

Another phenomenon that has not been scrutinized in any depth is the disruptive impact of strategies of regionalization and the way in which they can be used to destabilize the influence of major stakeholders. If employed strategically, governance reforms can potentially diminish the influence of groups that exercise influence over particular aspects of the health system. The first iteration of regionalization across Canada, for example, focused not only upon the delegation of administrative responsibility down from departments of health to RHAs but also up from local hospital boards and providers to RHAs. The influence of local providers at a community level was significantly diminished through this process (Black and Fierlbeck 2006). Concern by provincial governments over the influence of providers is currently evident in the refusal of departments of health to cede authority over physician services to health authorities notwithstanding the fact that administrative authority over the provision of basic services provided by primary care physicians would seem to constitute “governing, managing, and providing health services” (rowing) rather than “setting strategic policy direction” (steering). A province with several health authorities could conceivably argue that a provincial presence was necessary to coordinate certain functions (such as physician contracts) across all health authorities. Yet even in provinces that have amalgamated all health authorities into one entity, departments of health have been unwilling to transfer responsibility for physicians to the provincial health authority, despite the resulting administrative bifurcation between primary and acute healthcare services. This would seem to suggest that the desire to govern health systems according to a clear distinction between rowing and steering is subordinate to the provinces’ desire to maintain direct control over a powerful stakeholder group. It also raises important questions about the provincial governments’ willingness to micromanage administrative issues when they become highly political.

… departments of health have been unwilling to transfer responsibility for physicians to the provincial health authority …

But physicians are not the only healthcare providers who have been strategically affected by shifting governance structures. During the recent process consolidating Nova Scotia’s nine health authorities into one, for example, the provincial government endeavoured to use the process to sideline a nurses’ union with a history of achieving high-wage settlements (which consequently served as benchmarks
for the rest of the public sector). An important aspect of health authority amalgamation in Nova Scotia was the consolidation of over 50 healthcare bargaining units into 4. Rather than permitting run-off votes to determine which bargaining agent would represent workers in any category represented by more than one union prior to restructuring, the province appointed a mediator–arbitrator to distribute healthcare workers into each of four categories and to assign a bargaining agent for each of them. The mediator–arbitrator, however, declared that the principle of majoritarianism was a fundamental prerequisite for legitimate representation and that allocation to bargaining units would only be done on that basis. When the mediator–arbitrator assigned two of the four bargaining units to the very union that had successfully negotiated high-wage settlements in the past, the Minister of Health and Wellness declared that the mediator–arbitrator had “failed to fulfill his mandate,” and that the province itself would introduce legislation to determine which union would represent what bargaining units. When it became apparent that this move would likely precipitate a challenge under section 2(d) of the Canadian Charter of Rights and Freedoms, the province backed down and ultimately negotiated a system of multilevel “Councils” comprised of discrete unions.

It is disingenuous to suggest that health policies at any level can be extricated from the political context within which they are designed and implemented. Governments are responsible to patients, but they are also responsible to voters and taxpayers, and it is fatuous to suggest that the political calculations made by governments could or should be eliminated. For better or worse, policy making is embedded in a larger context of democratic governance; and democracy at its rawest is about the ability of those in power to win or maintain the support of the citizenry. A health system may have the provision of healthcare at its core but, like most policy areas, it is also a mechanism through which to elicit sufficient political support to maintain the governing party in power.

Is it possible to limit the way in which regionalization is used strategically for political purposes?

Notwithstanding any real policy outcomes, strategies of regionalization are useful politically. The concept of regionalization is amorphous enough to serve a range of political ends; it contains simple and credible causal claims; and there is little irrefutable evidence to either support or negate the merit of these claims. Is it possible to limit the way in which regionalization is used strategically for political purposes? One could, perhaps, subject them to the same scrutiny given to therapeutic treatments. To use the metaphor of evidence-based medicine, the utility of regionalization as prescribed treatment would then depend upon being clear about what the ailment is (what is it, precisely, that regionalization is expected to improve?); what the treatment is expected to do; what the evidence base is; what the precise causal pathways are; and what the harms as well as benefits of treatment are.

The problem, of course, is that health policies, and especially wide-ranging ones such as regionalization, are qualitatively distinct from therapeutic drugs or medical procedures. An “evidence-based” approach to comprehensive policies like regionalization will always face significant epistemological limitations. It is, in the first place, difficult to isolate clear causal relationships simply because there are so many potential confounders that may be relevant in such wide-ranging initiatives. It would, for example, be extremely
difficult to determine whether the consolidation of health authorities across a province was itself responsible for a decline in administrative costs, as a multitude of other variables (such as the implementation of new health IT systems) might also have had a causal impact. Replication, another foundational principle of evidence-based medicine, is impossible for the same reason. Regionalization strategies fall into a category that Pawson (2006: 25) calls “complex systems thrust amidst complex systems,” and it is highly unlikely that one could ever articulate a generalizable theory about how policies of regionalization, or any other complex sociopolitical interventions, consistently and predictably work (Marchal et al. 2013).

This is not to say that one should not collect and scrutinize the performance of healthcare systems as they implement and revise various permutations of regionalization; even “N of one” studies can be quite informative. But in answering the question, “why do polities choose to adopt (or modify) strategies of regionalization?,” the epidemiologists’ concentration upon outcome measures is usefully complemented by the political scientists’ focus upon identifying whose interests are furthered and whose are impeded, by specific policy choices. Regionalization seems to have a remarkably enduring quality: it has been said that cockroaches and RHAs are the only two things that will survive a nuclear holocaust (Godlee 2016). Given the absence of convincing evidence demonstrating its capacity to achieve specific outcomes, the appeal of regionalization must rest at least in part with its political utility.

References


Lost in Maps: Regionalization and Indigenous Health Services

COMMENTARY

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ABSTRACT

The settlement of the land now known as Canada meant the erasure — sometimes from ignorance, often purposeful — of Indigenous place-names, and understandings of territory and associated obligations. The Canadian map with its three territories and ten provinces, electoral boundaries and districts, reflects boundaries that continue to fragment Indigenous nations and traditional lands. Each fragment adds institutional requirements and organizational complexities that Indigenous nations must engage with when attempting to realize the benefits taken for granted under the Canadian social contract.
This paper discusses how the implementation of regionalized forms of health system governance at the provincial level continues to perpetuate state-centric territorial administration and control of Indigenous peoples and Indigenous health and well-being, imposing new boundaries on Indigenous territories, fragmenting and marginalizing Indigenous communities and perspectives and further splitting service delivery across a proliferation of jurisdictions. The argument is organized along three main themes. The first discusses the colonial imposition of territorial boundaries and the resulting impacts on Indigenous health and well-being. The second distinguishes concepts of colonial territoriality from Indigenous land-based reciprocity, examining the impact of the colonial territorial paradigm on treaty-making, land claims and health governance and delivery. A final section explores issues of Indigenous representation on health authorities (HA)/boards as a counter to imposed territorial paradigms. We conclude with key lessons.

Colonization: Imposing Federal and Provincial Control over Health Services

Prior to colonization, Indigenous peoples living in what is now known as Canada, existed within their own jurisdictions and governed themselves according to their own legal, social and political systems. As a result, Indigenous nations were responsible for the health and well-being of their people and enjoyed a measure of well-being much higher than is currently observed in a majority of Indigenous communities across Canada (Boyer 2014). Colonization and the establishment of Canada entailed a unilateral imposition of federal and provincial jurisdictional boundaries on Indigenous communities, and the imposition of healthcare systems.

The British North America Act (renamed the Constitution Act) of 1867 created a jurisdictional divide that remains to this day. Under section 91(24), “Indians and lands reserved for Indians” were allocated as a federal responsibility under federal jurisdiction, whereas the responsibility for healthcare was allocated to the provinces, leaving Indigenous health in this jurisdictional gap. The current jurisdictional map counts fourteen healthcare systems. The thirteen provincial and territorial governments are responsible for the delivery of a range of health services, defined by the Canada Health Act 1984. The Act mandates publicly provided hospital and physician services, leaving room for regional variation of ensured services based on provincial priorities, such as Pharmacare or long-term care.

The fourteenth, and often forgotten healthcare system, is provided by the First Nations and Inuit Health Branch (FNIHB) of Health Canada, which funds and, to a lesser extent, delivers healthcare services to First Nations living on-reserve (all provinces and in the Yukon) and Inuit (in Newfoundland and Labrador only). The federal government has the prime responsibility for a complement of prevention and primary care health services provided to “Status Indians” living on reserve and to Inuit living in their traditional territories in Québec and Labrador. This system does not, at the moment, provide services to Métis, who only recently have become acknowledged as eligible to federal programs as defined under the Indian Act (2015 Daniels v Canada). At the time of writing, Métis are still awaiting the final decision of the Supreme Court of Canada. However, it appears unlikely that FNIHB, which has been actively engaged in transferring its role as the provider of health services to First Nations for
three decades (Lavoie et al. 2009: 18), and in off-loading responsibilities to provincial jurisdictions (Lavoie and Forget 2006), might step forward to extend health services to Métis.

Federal and provincial policies move at different paces and follow different priorities, sometimes closing jurisdictional gaps, though often opening new ones. Given this combination of multi-jurisdictional boundaries and service variation, services provided to First Nations, Métis and Inuit peoples are often the subject of jurisdictional disputes (Lavoie et al. 2015; The Jordan’s Principle Working Group 2015).

Territoriality, Treaties and the Governance of Health

The paradigm that underpins jurisdictional boundaries is based on the concept of territoriality or the exclusive control of bounded geographic space and the contents, including people, within those boundaries (Sack 1986). The colonial imposition of territorially defined authority imposes forms of spatial organization and conceptions of geographic space that predetermine the kinds of relationships between people, places, things and authorities that are possible within a given jurisdiction (Kornelsen 2015). The colonial state, then, is taxed with developing putatively just forms of the distribution of resources (including healthcare) across those living within these fixed boundaries. This concept of territoriality is at odds with many Indigenous epistemologies that understand jurisdictions and just distributions in relational terms – that is, that land is not something to be arbitrarily divided and controlled but something to build relationships with. This paradigm extends to the just distribution of “resources” or obligations between individuals and between communities that are defined and underwritten relationally, by developing respectful/reflexive relations of reciprocity (Asch 2014; Simpson and McDonald 2011) as expressed in traditional practices of treaty-making. The colonial project is continuously focused on displacing Indigenous concepts of land and stewardship, in favour of a static notion, aligned with the concept of private property and its mutually exclusive use of land set by static boundaries.

This territorial paradigm framed the establishment of the Canadian federation as well as the very practice of treaty-making in colonial contexts (historically and in the present) in ways that not only directly contradict Indigenous rights to self-determination but also continue to have significant deleterious effects on Indigenous health and well-being. Indigenous rights are entrenched in the Royal Proclamation of 1763 (King George 1763) – a document issued to clarify the rights of the French and Indigenous minorities following the conquest of New France by Britain. This document states that the Indigenous population is not conquered; they retain title over their ancestral territory and encroachment must be negotiated and settled by Treaty. As can be seen in Table 1, the signing of Treaties (1871–1921) and land claims agreements (1975 to present) were and are intended to “settle” issues of territoriality and federal obligations, based on this concept of exclusive use. The result is a patchwork of territorially defined jurisdictions of exclusive control, perpetuating disagreement between federal or provincial authorities on who is responsible for the “contents,” as well as pitting Indigenous communities against each other as they vie for federal/provincial resources. The imposition of new territorial boundaries on Indigenous nations, which arbitrarily fragmented some nations across different jurisdictions, also resulted in a constellation of small discrete communities.
### Table 1. Treaties and self-government activities in relation to Indigenous health

<table>
<thead>
<tr>
<th>Agreement</th>
<th>Signed</th>
<th>YK</th>
<th>NT</th>
<th>NU</th>
<th>BC</th>
<th>AB</th>
<th>SK</th>
<th>MB</th>
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<th>QC</th>
<th>NB</th>
<th>NS</th>
<th>NF</th>
<th>NL</th>
<th>ED</th>
<th>Relationship to Health</th>
<th>Commitment for specific services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treaty No. 1 (Canada 1871)</td>
<td>1871</td>
<td></td>
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<td></td>
<td></td>
<td>✓</td>
<td>Implied commitments</td>
</tr>
<tr>
<td>Treaty No. 2 (Canada 1871)</td>
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<td>✓</td>
<td>✓</td>
<td></td>
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<td></td>
<td></td>
<td>✓</td>
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<td>Treaty No. 3 (Canada 1873)</td>
<td>1873</td>
<td>✓</td>
<td>✓</td>
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<td></td>
<td></td>
<td>✓</td>
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<tr>
<td>Treaty No. 4 (Canada 1874)</td>
<td>1874</td>
<td>✓</td>
<td>✓</td>
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<td></td>
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<td>Treaty No. 5 (Canada 1875)</td>
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<td>✓</td>
<td>✓</td>
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<td>Treaty No. 6 (Canada 1876)</td>
<td>1876</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>Treaty No. 7 (Canada 1877)</td>
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<td></td>
<td></td>
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<tr>
<td>Treaty No. 8 (Canada 1899)</td>
<td>1899</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>Verbal commitments, none included in the text of the Treaty</td>
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<tr>
<td>Treaty No. 9 (Canada 1929)</td>
<td>1905–06</td>
<td>✓</td>
<td></td>
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<td>Treaty No. 10 (Canada 1906)</td>
<td>1906</td>
<td>✓</td>
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<td>Treaty No. 11 (Canada 1921)</td>
<td>1921</td>
<td>✓</td>
<td>✓</td>
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<td></td>
<td></td>
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<tr>
<td>James Bay and Northern Quebec Agreement (Canada 1974)</td>
<td>1975</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>Northeastern Quebec Agreement (Canada 1984)</td>
<td>1978</td>
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<td>✓</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>Inuvialuit Final Agreement (Canada &amp; Committee for Original Peoples’ Entitlement 1984)</td>
<td>1984</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
<td>✓</td>
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<tr>
<td>Sechelt Indian Band Self-Government Act (Canada &amp; Sechelt Indian Band 1986)</td>
<td>1986</td>
<td>✓</td>
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<tr>
<td>Agreement</td>
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<td>YK</td>
<td>NWT</td>
<td>NU</td>
<td>BC</td>
<td>AB</td>
<td>SK</td>
<td>MB</td>
<td>ON</td>
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<tr>
<td>The Umbrella Final Agreement (Canada &amp; Council for Yukon Indians 1993)</td>
<td>1993</td>
<td>✓</td>
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<td>Sahtu Dene &amp; Métis Comprehensive Land Claim Agreement (Canada &amp; Sahtu Tribal Council 1994)</td>
<td>1993</td>
<td>✓</td>
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<td>Nunavut Land Claim Agreement (Canada &amp; Nunavut Taparit Kanatami 1993)</td>
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<td>✓</td>
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<tr>
<td>Indian Self-Government Enabling Act (British Columbia 1996b)</td>
<td>1996</td>
<td></td>
<td></td>
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<tr>
<td>Indian Advisory Act (British Columbia 1996a)</td>
<td>1996</td>
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<td>The Nisga’a Final Agreement (Canada &amp; Nisga’a Tribal Council 1999)</td>
<td>1999</td>
<td></td>
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<td>✓</td>
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<td>The Métis Act (Saskatchewan 2001)</td>
<td>2001</td>
<td></td>
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<tr>
<td>Tlicho Agreement (Canada, Government of the Northwest Territories &amp; The Tlicho 2003)</td>
<td>2003</td>
<td>✓</td>
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</table>

<table>
<thead>
<tr>
<th>Relationship to Health</th>
<th>Some control over health services</th>
<th>Input into policy/regulations</th>
<th>Commitment for specific services</th>
</tr>
</thead>
<tbody>
<tr>
<td>YK</td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>NWT</td>
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</tbody>
</table>

67
Treaties and land claims agreements make varying healthcare-related commitments to signatories. Of the historical Treaties (the numbered Treaties, signed between 1871 and 1921), Treaty 6, which includes over 50 First Nations in central Alberta and Saskatchewan, is the only one to make a healthcare-related commitment in writing. The Medicine Chest clause charges the federal government with the responsibility to protect First Nations people from pestilence and famine and to provide a “medicine chest” in the house of each Indian agent (Backwell 1981). While First Nations representatives view these provisions as the basis for a full federal obligation for health, the federal government has adopted the position that the provision of medical care is a matter of policy and not of right (Boyer 2004). This position is based on the 1966 Supreme Court of Saskatchewan, known as the Johnston appeal, which stated that “the [medicine chest] clause itself does not give to the Indians the unrestricted right to the use and benefit of the ‘medicine chest’ but such rights as are given are subject to the direction of the Indian agent.” Therefore, according to this interpretation, the federal government determines the legitimacy of Indians’ request for healthcare and to allocate it free of charge or at a cost (Canada 1966).

Since 1974, some lands claim agreements have included health-specific provisions. The James Bay and Northern Quebec Agreement (1975) and the Nisga’a Final Agreement (1999), give signatories some level of control over policy and health service delivery. The majority of these agreements, however, focus on input into policies and regulations over services to be provided by the province or territory. See details in Table 1.

The consequences of this jurisdictional uncertainty regarding health has been significant for First Nations, Inuit and Métis peoples in Canada. The federal government is responsible for providing health services for First Nations people living on reserve, primarily through contribution agreements to the bands to run these health services. Band-run programs are only provided funding for Status First Nations who live on their home reserve, leaving nearly half of Canada’s First Nations people who live off reserve without funded access to on-reserve services. This limits the access that First Nations peoples living off reserve have to culturally appropriate services as they are forced to access mainstream systems for their healthcare needs. In addition, when there are gaps in coverage in on-reserve services, First Nations people living on the reserve do not necessarily get access to provincial services to address their unmet needs (The Jordan’s Principle Working Group 2015). This jurisdictional boundary leads to significant inequities and gaps in continuity of care, given that on-reserve services do not have the same funding resources as the provincially run programs (i.e., availability of after-hours care). Small communities are also expected to compete for program funding for health and other services.

Indigenous Participation as a Counter to Overlapping Maps and Jurisdictional Gaps
Trends in self-government have provided improved opportunities for First Nations and Inuit participation in service delivery. Agreements between federal and/or provincial health ministries/departments/HAs and First Nations and Inuit communities have multiplied. Self-government agreements have their own geographic boundaries.
Meanwhile, most provinces (with the exception of Prince Edward Island and more recently, Alberta and Nova Scotia) as well as the Northwest Territories have adopted decentralized models of healthcare delivery, which entails a transfer of authority from the Department of Health to regional authorities. Decentralization is intended to increase opportunities for citizen engagement in local priority setting, given that these regional authorities are tasked with priority setting and the allocation and management of health resources (Saltman et al. 2007). The relationship between Indigenous nations and HAs vary across the country. In effect, regionalization has added yet another level of complexity and variation in the complement of services accessible to all residents, including Indigenous communities.

Most decentralized provincial healthcare systems have not entrenched mechanisms to ensure Indigenous representation. Specific provisions are listed in Table 2. Ontario is the only province to have established a council composed of Indigenous peoples to advise on regional priority setting in healthcare, which is provided through the LHINs, although this is simply an advisory role. BC and Nova Scotia have had provisions that stipulate that the make-up of the Board of Directors must reflect the population that the RHAs are set up to serve; Indigenous peoples had not been specifically mentioned. This changed in BC as a result of the 2011 Tripartite Agreement on First Nations Health Governance, which includes explicit language to direct the RHAs to work collaboratively with First Nations in the planning and delivery of health services (Government of Canada, Government of BC and the First Nations Health Society 2011). New tables for discussion and negotiation of First Nations priorities have been established in every regional health authority (RHA) in BC, although the scope has focused on Indigenous-specific services, rather than the full range of health services that Indigenous people use. This innovation is unprecedented and unique to BC.

Discussion and Conclusion

While commitments to self-determination create opportunities for some level of Indigenous control over selected health services, the entire framework remains mired in territorial assumptions that legitimize imposed colonial boundaries and the kinds of competitive, control-based relationships that follow. As such, federal, provincial, regional and Indigenous authorities over health services remain fragmented, and responsibilities debated. This is particularly the case for First Nations. The creation of HAs in most provinces did not resolve these issues. While Ontario (with Indigenous advisory committees for the LHINs) and BC (with regional tables on First Nations health) have established these advisory bodies to recommend and press for Indigenous priorities within the HAs, these are not recognized as decision-making bodies within those authorities, but rather to advise on Indigenous priorities. Therefore, legislation of provincial HAs has yet to guarantee Indigenous representation on their boards.

Although representation is important to advance the goals of Indigenous peoples in Canada, the appointment of a First Nations, Metis or Inuit individual on a board, tasked to represent all Indigenous peoples in the region, itself contradicts the principle of self-determination. And while Aotearoa (New Zealand) has engaged with this complexity and developed pathways (Lavoie et al. 2012), Canadian provinces have yet to begin these conversations.
A possible pathway is now being travelled by the BC First Nations Health Authority (FNHA). Created as a result of a tripartite agreement set to address health and other inequities experienced by First Nations, BC is witnessing a new era in Indigenous health.

Table 2. Indigenous representation in regionalized models

<table>
<thead>
<tr>
<th>Province/territory</th>
<th>Pop. 2015 (000)</th>
<th>% of pop. Indigenous</th>
<th>Number of RHA in 2015</th>
<th>Members are</th>
<th>Provisions entrenching Indigenous participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>YT</td>
<td>37</td>
<td>25</td>
<td>Not regionalized</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>NT</td>
<td>44</td>
<td>50</td>
<td>6+</td>
<td>Appointed</td>
<td>No specific provision to ensure Indigenous representation (Government of the Northwest Territories 1988, and amendments)</td>
</tr>
<tr>
<td>NU</td>
<td>37</td>
<td>85</td>
<td>Not regionalized</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>BC</td>
<td>4,683</td>
<td>5</td>
<td>5+</td>
<td>Appointed</td>
<td>Article 7.6.4 states that “the membership of public sector boards should reflect the cultural and geographical makeup of the population” (The Board Resourcing and Development Office 2007)</td>
</tr>
<tr>
<td>AB</td>
<td>4,196</td>
<td>6</td>
<td>1</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>SK</td>
<td>1,134</td>
<td>15</td>
<td>13</td>
<td>Appointed</td>
<td>No specific provision to ensure Indigenous representation (Saskatchewan Health 2008)</td>
</tr>
<tr>
<td>MB</td>
<td>1,293</td>
<td>15</td>
<td>5</td>
<td>Appointed</td>
<td>No specific provision to ensure Indigenous representation (Manitoba 2008)</td>
</tr>
<tr>
<td>ON</td>
<td>13,742</td>
<td>2</td>
<td>14</td>
<td>Appointed</td>
<td>According to the Principles Governing the Appointments Process, the “Persons selected to serve must reflect the true face of Ontario in terms of diversity and regional representation.” The Local Health System Integration Act requires the creation of an Aboriginal and First Nations Health Council to advise the minister about health and health services related issues (Ontario Public Appointment Secretariat 2007)</td>
</tr>
<tr>
<td>QC</td>
<td>8,264</td>
<td>1</td>
<td>18</td>
<td>Appointed</td>
<td>No specific provision to ensure Indigenous representation (Gouvernement du Québec 2005)</td>
</tr>
<tr>
<td>NB</td>
<td>754</td>
<td>2</td>
<td>2</td>
<td>Elected/Appointed</td>
<td>No specific provision to ensure Indigenous representation (New Brunswick 2002)</td>
</tr>
<tr>
<td>NS</td>
<td>943</td>
<td>3</td>
<td>1</td>
<td>Appointed</td>
<td>According to the regulations, “the following are to be considered assets in the consideration of candidates for nomination: population characteristics such as age, gender, ethnicity, geography or membership in a disadvantaged group” (Nova Scotia 2000)</td>
</tr>
<tr>
<td>PE</td>
<td>146</td>
<td>1</td>
<td>1</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>NL</td>
<td>528</td>
<td>5</td>
<td>4+</td>
<td>Appointed</td>
<td>No specific provision to ensure Indigenous representation (Government of Newfoundland and Labrador 2005)</td>
</tr>
</tbody>
</table>

Pop. = population.
This new era has enabled: forging a relationship between the FNHA and the BC Ministry of Health; facilitating partnerships between First Nations and the HAs in all five BC regions; working toward greater policy and service integration throughout the province; and recognizing that Indigenous health is a joint responsibility of all the partners. The impact of this shift has not fully materialized, but it has brought key health and First Nations leaders to the table to collaboratively address the gaps in Indigenous health in ways not seen in other parts of Canada. It remains to be seen whether new governance formulations like this can adequately inject norms of relationship-building and reciprocity reflective of an Indigenous worldview to define relations between Indigenous nations themselves, and between Indigenous nations and federal and provincial authorities (Government of Newfoundland and Labrador, 2005).

Notes
1. The term “Indian” is a remnant from colonial confusion (related to Columbus’ belief that he had “discovered” a route to India) that remains in legal documents. “Status Indians” are those individuals recognized as Indians as defined in the Indian Act 1985, c. This recognition confers eligibility to certain services and programs.
2. In Canada, the term “Aboriginal” is entrenched in the Constitution Act, 1982, and includes First Nations, Métis and Inuit. Aboriginal is used here when referring to historical references, otherwise the terms First Nation, Métis and/or Inuit are used. The term “Indigenous” is the preferred global term.

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Means to an End
As the authors in these essays emphasize, regionalization is merely a means to achieve defined goals and objectives. It is not a goal in itself. As pointed out in their extensive review of health regions in Canada, Yves Bergevin and his colleagues (2016) correctly identify regionalization as “one of the main organizing strategies” of provincial health systems in Canada in the last quarter century. But, as discussed in my introductory essay and repeated in a number of the essays presented here, regionalization itself is simply a vehicle to achieve a number of objectives all intended to improve health system performance, including the quality of care and patient responsiveness.

Gwyn Bevan (2016) goes further. He argues that the early regionalization of the National Health Service (NHS) in the United Kingdom was not even necessary, much less sufficient, to achieve what he isolates as its key administrative objective, to facilitate the coordination and integration of care. Based on the more recent natural experiment of de facto creation of health regions for Scotland, Wales and Northern Ireland through devolution, Bevan argues that improved performance through greater coordination and integration was the product of hierarchical planning and performance management accompanied by hard sanctions and tight regional governance and monitoring of performance.

Similarly, Karsten Vrangbaek (2016) provides a tantalizing list of Danish initiatives to improve coordination and integration orchestrated by the central government to support the five regions in the country responsible for hospital and physician care and the 98 municipalities responsible for almost all other healthcare services, including the following:

- Patient pathway programs and standards to develop more integrated services for various chronic conditions (e.g., diabetes).
- Hospital-based outreach teams conducting post-discharge follow-up visits in patients’ homes.
- Creation of multi-disciplinary “health houses” and medical homes.
- Use of GP practice coordinators to facilitate communication across health service organizations on behalf of patients.
• Agreements between regions and GPs to increase responsibility and accountability for coordination and integration.

Stephen Duckett (2016) points to the resource allocation function of health regions and the presumption that more regionally-based organizations can be expected to be more responsive to local needs in getting the right mix of investment across various types of healthcare. Of course, if this task is not carried out properly, it can result in significant under-investment in certain types of care, thereby impeding integration and coordination with other services.

Politically motivated structural health system reform has been a regular part of the Canadian landscape …

How this coordination and integration occurs is a significant question. As Bevan (2016) and Tim Tebensel (2016) point out, it can occur through hierarchy or the market. Most systems mix and match depending on the type of health services and providers involved. Some arrangements are difficult to describe. Canadian physicians, for example, are independent contractors and many continue to be paid on a fee-for-service basis. Medicare evolved into a highly corporatist arrangement between provincial governments and organized medicine that has actually made top-down reform at the provincial ministry or the regional health authority (RHA) levels very difficult. This stands in sharp contrast to the top-down reforms in New Zealand, Denmark and the UK discussed here.

However, regionalization is not all about policy and administration. There are also significant political objectives. Katherine Fierlbeck (2016) describes the potential political benefits of regionalized structures (whether decentralized or centralized) for the political tier of government. Certainly, at least some political leaders hoped that the boards and CEOs of RHAs would wear at least some of the difficult decisions in the initial stages of regionalization. While opposition parties and the media made sure that did not happen, there was another political use of RHAs that was even more ubiquitous: focusing reforms at the higher administrative and structural health system levels because such reforms are less disruptive to voters and providers than service delivery reforms.

Politically motivated structural health system reform has been a regular part of the Canadian landscape since regionalization was introduced in the early to mid-1990s. Perhaps the most infamous example is the Alberta government’s decision to disband its RHAs in favour of a single delivery agent. Political concerns about CEO remuneration and the bureaucratic rivalry between the Calgary and Edmonton health regions and competitive vying for resources from the provincial government were likely the determining reasons for the change in direction. At the same time, there has been a noticeable trend toward greater centralization in regionalized systems inside and outside Canada in recent years.

Centralization
Regionalization has always involved a combination of centralization up from healthcare organizations to a regional body and a delegation of resource allocation and managerial decision-making from health ministries to regional bodies. As noted in the introductory essay (Marchildon 2016), there has been a marked trend to more centralized structures, either in terms of reducing the number of RHAs or creating single province-wide health authorities.

As Duckett (2016) points out in his essay, the balance between decentralization
and centralization changes over time and the pendulum may once again shift back to more decentralized structures in the future in Canada. In the meantime, it is important to understand that there are both costs and benefits to both decentralized and centralized structures, and the enormous challenge faced by provincial governments in getting the tension between the two just right.

While provincial governments are aware that healthcare is too complex and varied to be entirely managed by a ministry, they want to be able to obtain economies of scale and scope that seem to be easiest to achieve under a single delivery organization. However, bureaucratic overload often accompanies the multiple hierarchical levels of authority in large organizations. Alberta Health Services (AHS) has 100,000 employees and is one of the largest employers in Canada. It is, in fact, a mini version of the NHS, one of the largest employers in Europe. However, it is questionable whether the scale and scope advantages of such an enormous organization ever outweighed the inefficiencies associated with such size, and the continual reforming of the NHS since the early 1970s could be seen as an effort to decentralize.

Despite these lessons from other jurisdictions, it is unlikely that the trend to centralization has run its course in Canada. Indeed, there is little evidence of a counter-trend to increasing, rather than reducing, the number of RHAs. We can only hope that the political decisions taken in the near future will more carefully weigh the advantages and disadvantages of centralization based on experiences in Canada and outside Canada.

**The missing pieces**

In reviewing the experience with regionalization in other countries, it is difficult not to be struck by the extent to which physicians work outside of regionalized structures everywhere in Canada. This can be seen most readily when it comes to primary care. In the New Zealand case, Tebensel (2016) shows how GPs were required to become part of Primary Health Organizations (PHOs) with accountability requirements set by statute and a direct linkage with the District Health Boards. This structure is very similar to what was recommended to the Ontario government by the Primary Health Care Expert Advisory Committee in 2015. However, the Ontario Medical Association’s (OMA) opposition to the recommendation will make it extremely difficult for the government to adopt without a major conflict with organized medicine (Marchildon and Hutchison 2016).

Indeed, the relationship between physicians and regionalized structures, particularly as it affects primary care, has been identified as a major impediment to improving health system performance. In their major review of regionalization in Canada, which has been summarized here, Yves Bergevin and his colleagues (2016) point to the lack of accountability between physicians and RHAs and the implications of this in terms of improving health services. The reality is that those countries, such as the UK and New Zealand, where major changes to this accountability relationship have occurred, have experienced significantly better outcomes in terms of health system performance, at least as measured in the Commonwealth Fund’s International Survey.

The Truth and Reconciliation Commission of Canada (2015) delivered its landmark report in December 2015. Since that time, there has been considerable discussion of how the country can get beyond its paternalistic foundation and racist settler-Aboriginal relationship, so that Canada’s Indigenous peoples can be in greater control of the decisions that affect their lives. Since health and healthcare will be major factors in this reconfiguring of Canadian society,
Josée Lavoie and her colleagues (2016) were asked to examine the interface between regionalization and Indigenous health and healthcare.

At this time, only two provincial health systems have formal structures for Indigenous input into regionalized structures. The government of British Columbia requires public sector boards, including the government-appointed RHA boards, to reflect the cultural and geographical make-up of the populations they serve. Ontario’s Local Health System Integration Act requires an Aboriginal and First Nations Health Council to advise the provincial Minister of Health on Indigenous health and health services issues. These requirements are limited to advisory functions and do not go as far as involvement of the Maori in health system decision-making in New Zealand, for example. However, the recently created First Nations Health Authority (FNHA) is intended to be a direct actor in determining health and health services for Indigenous residents in British Columbia. It is difficult at this point to see how the FNHA will work with the province’s five RHAs, but the experiment is being watched in other provinces to see if the model can, and should, be adapted to other environments.

Conclusion

In Canada, due to the history of public payment and private delivery (Naylor 1986), governments have had to collaborate more with private actors – particularly the medical profession – to achieve health system changes than has been the case with governments in the countries examined here. This will likely continue to be the case when it comes to doctors and it will certainly be true when it comes to the manner of involving and serving Indigenous populations in Canada. At the same time, this onus on governments makes it more difficult to orient policies, programs and incentives to increase the integration and coordination of health services through regionalized structures. The paradox is, however, that without this integration and coordination within or outside regionalized structures, it will be difficult to improve health system performance.

I will conclude by repeating (sometimes paraphrasing) the seven areas of improvement identified by Yves Bergevin and his co-authors (2016), and then suggesting, in parentheses, some potential concrete actions.

• Managing RHAs as a results-driven health system (provincial ministry of health setting hard targets for RHAs with explicit consequences for failure).
• Strengthening wellness promotion and public health including intersectoral actions and policies (encouraging RHAs to identify at least one public or population health intervention that requires collaboration and policy synergy with local governments within its defined geographic boundaries).
• Ensuring timely access to primary healthcare (require patient registration with primary care practices and, simultaneously, require primary care practices to provide full 24/7 coverage as part of remuneration package).
• Involving physicians in clinical governance and leadership and have RHAs partner with them to improve accountability and performance (either transfer physician budgets to RHAs or create an intermediary organization that would create ...
an accountability relationship between physicians and RHAs with performance requirements).

- Engaging citizens in shaping their own health destiny and their respective health systems (ensure greater transparency for citizens at the RHA and ministry levels with more regular public consultation and engagement by RHAs and ministries with citizens on long-term direction and priorities).
- Strengthening health information systems, accelerating the deployment of electronic health records and ensuring their interoperability with health information systems (launch a federal–provincial–territorial process with a definite deadline with the objective of providing all Canadian citizens with comprehensive electronic health records that they can access and use at any time).
- Fostering a culture of excellence (creating a pan-Canadian forum that regularly showcases health organization and delivery innovations and based on a juried assessment of international originality and target population impact).

These actions are not comprehensive. Nor are they particularly simple or easy, given the current governance and administrative arrangements and the power wielded by some interest groups. However, they are intended to begin a discussion about the actions needed to actually improve what most agree is the suboptimal performance of most health systems in Canada, whether defined at the provincial or the regional level. Faute de mieux, regionalization remains the most viable means to achieve this end.

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