Revisiting Health Regionalization in Canada: More Bark Than Bite?

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Abstract
Twenty years ago, many of Canada's provinces began to introduce regional health authorities to address problems with their health care systems. With this action, the provinces sought to achieve advances in community decision-making, the integration of health services, and the provision of care in the home and community. The authorities were also to help restrict health care costs. An assessment of the authorities indicates, however, that over the past two decades they have been unable to meet their objectives. Community representatives continue to play little role in determining the appropriate health services for their regions. Gains have been made towards integrating health services, but the plan for a near seamless set of health services has not been realized. Funding for health services remains focused on hospital and physician care, and health care expenditures have until very recently been little affected by regional authorities. This disappointing performance has caused some provinces to abandon their regional authorities, but this article argues that the provision of greater autonomy and a better public appreciation of their role and potential may lead to more successful regional authorities. Accordingly, the objective of this article is to reveal the shortcomings of regional health authorities in Canada while at the same time arguing that changes can be made to increase the chances of more workable authorities.

Keywords
regionalization, health authorities, Canada

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At the start of the 1990s, nearly all of Canada’s provincial governments began an ambitious attempt to reform the organization of their health care plans. One provincial study after another had shown that the plans suffered from various problems – among others, high cost, uncoordinated delivery of services, and the near absence of community involvement in decision making. The studies then recommended as a response to these problems the introduction of a new organizational entity called the regional health authority or RHA. The proposed reform, adopted by nine of the ten provinces, involved a bold scheme to decentralize responsibility for the administration of major health programs and to centralize authority over the operation of these same programs by eliminating hospital boards and other local health agencies. The beneficiary of this simultaneous upwards and downwards movement of power, the RHA, would strive to address the weaknesses and failings of the best known public program in Canada. The new health agency would function to give provinces the kind of health plans that provided more integrated and responsive services at an acceptable cost. The new arrangement also relieved health ministries of a substantial part of their administrative duties and allowed them to pay greater attention to the performance and direction of health plans.

When regional health authorities were first introduced, some believed that the challenges inherent in the objectives of the newly-implemented bodies made it most unlikely that they would succeed.1 Such an assessment was based on evidence arising from relevant experiences found elsewhere. This article considers the evidence relating to the operation of Canada’s regional health boards since their inception and finds that the expectations of these agencies have largely gone unmet. Health care costs continue to rise, important services remain often isolated from each other, and community members still find themselves mostly without influence. The decision of four provinces, Prince Edward Island, New Brunswick, Alberta, and Nova Scotia, to end their experiment with health authorities also speaks to the feeling of disappointment with the authorities, and there are signs that other provinces may follow. More ominously, an underlying dynamic of the RHA, the notion of placing financial and operational authority with a regional body and leaving the central government responsible for evaluation and planning, is at risk. This development is linked to the reluctance within governments to leave any serious degree of responsibility to agencies outside the control of political leaders2 and a belief that the stark division of planning and administration within the public sector is unworkable.3 Admittedly, the RHAs have made some advances in dealing with well-known problems afflicting provincial health plans. Health care services, for example, are more integrated than they were before the advent of regionalization. However, these improvements have been unable to dispel the overall sense of dissatisfaction with regional health authorities.

Despite this less than positive assessment of RHAs in Canada, it is still possible to take actions that could help to bring out the potential inherent in the
regionalization of health care. This article considers such actions with the understanding that any attempt to enhance the operation of Canada’s regional health authorities is an uphill struggle.

**Rise of Health Authorities**

In the late 1980s and early 1990s provincial governments in Canada undertook thorough examinations of their health care systems to deal with concerns that had emerged over the years. These concerns included a heavy reliance on institutional care while ignoring the efficacy of community-based services; lack of integration and coordination of care because of stove-piping at the provincial level and multiple decision-making bodies at the local level; an absence of sufficient attention paid to health promotion and prevention; a dearth of responsiveness and accountability to the local community; and, last, but not least, an inability to handle escalating health costs.\(^4,5\)

Altogether the reports indicated that there were serious problems with provincial health plans. The question was how to counter these concerns. These same reports outlining the troubles with health care also had an answer to the query – regional health authorities. In choosing RHAs, almost all of the provincial governments sought to alter the governance and delivery of health care. On the governance side, the traditional model of governing revolved around hospital and public health boards responsible for service delivery. Embedded within this model was a political relationship that saw local provincial politicians working with local hospital boards and physicians to increase health care resources for local communities. This worked well until the late 1980s, when priorities of senior provincial politicians located in cabinet challenged the traditional model. Weary of negotiating with hundreds of local health boards over scarce health resources, the senior politicians eliminated the boards and replaced them with regional health agencies.

On the service-delivery side, the RHAs could contribute to the integration of services, especially the coordination of institutional and community-based care, and more generally address the costs of health plans. They also seemed ideal for encouraging greater community participation and program responsiveness, and they could also give health departments time to determine where provincial health plans should be going. All of this and more would be accomplished by transferring authority for many of the health programs from centrally-located ministries to entities found in provincial RHAs. The centralization of governance through the elimination of local health boards and agencies would be accompanied by the decentralization of responsibility for providing key health care services.

The preference for a regional strategy also reflected new thinking about the relationship between senior elected officials and the permanent public service in a parliamentary system. The traditional way of thinking could be seen as centred
on a bargain between ministers and appointed officials. The latter would offer advice to the former who in turn would use this counsel to make the final decision on the appropriate policy directive; once the policy had been approved, it would be handed over by the responsible minister to non-partisan appointed officials, who would implement the policy in accordance with specified rules and procedures. This worked for a period of time, when government was small and relatively inconsequential, but the advent of larger government made the arrangement less desirable. It now appeared inflexible with its commitment to rules and too far removed from the actual provision of services. The bargain also led to a loyalty to the top that made those responsible for implementation at times indifferent to recipients of services who might be able to suggest improvements. Also, for appointed officials the most rewarding work in terms of challenge and opportunities for advancement was to be found in policy advice, not administering programs, so problems with the operation of programs received scant attention. Finally, elected officials felt that the bargain gave too much influence to appointed officials, who were able to shape the final decision with their advice.

These failings of the bargain helped produce a new type of thinking about government and its organization labelled the New Public Management or NPM. The new thinking allegedly solved the failings through a separation of policy and administration or service delivery. If the problems of the old bargain lay partly in insensitivity, then it seemed sensible to make those responsible for service delivery more independent of those at the top and more accountable to the community; the greater autonomy afforded to administrators would also allow for a greater level of creativity and a willingness to try new things. Also, an effort could be made to break the monopoly of government officials over managing services and allow entities outside government to try their hand. As for those at the top, there was no need to feel that they had lost an important responsibility, for they could now focus on policy and planning and become less reliant on the advice of the bureaucracy. They would do the “steering” and leave the “rowing” to appointed officials and their heightened degree of autonomy.

The new thinking, coupled with the wish to alter the governance and delivery of health care services, helped supply the answer to problems with health care. Reviews of provincial health systems all urged governments to move forward with a strategy of regionalization that would break each of the provinces up into health regions and assign a regional authority to each region. With some variation, provincial governments devolved to the new RHAs the responsibility for the administration and financing of many of the components of provincial health plans, a clear adoption of the new way of organizing government. A relatively small number of RHA boards (some elected, most not) along with an administrative body headed by a chief executive officer replaced the plethora of existing hospital, home care and other local governing entities. A further
action was to embrace the new thinking fully by stipulating that the central ministries of health would now be more attuned to policy and planning. All in all, the proposed reform, which nine provinces had put into place by the end of the 1990s (and the tenth province, Ontario, a half-decade later), had seemingly adopted an ambitiously sensible way of tackling the serious problems hampering the operation of Canada’s health care system.

Impact of the Authorities

This paper asserts that the health authorities have fallen short of achieving an important impact on the problems that face provincial health plans, and the intent of this section is to provide support for this belief. But it is only fair to note before undertaking this exercise that the implementation of regionalization has not been entirely complete. The downwards transfer of authority has not been total; at a minimum, all authorities have been unsure about the nature of their power and found themselves to be victims of end-runs by those unwilling to accept the new regional arrangement. The same can be said of the upwards transfer of power, where the belief that the authorities would now take over from hospital and other health services boards has not been fully realized (and the late arrival, Ontario, had decided against such a transfer and left existing local boards intact). It is thus important to appreciate that the failings of authorities are not only a creation of their own efforts but also of faulty implementation.

Accountability and Citizen Participation

One of the underlying rationales for regionalization was a perceived lack of responsiveness of health decision-making to local communities. Those who received the care and also ultimately financed it through their taxes had little say over health care services and felt the absence of any real accountability. The lack of responsiveness took two basic forms. One was the difficulty of meeting the formal requirements of accountability, the other the inability to provide for effective citizen participation.

The regional health authorities have made efforts to respect the requirements of accountability, but as with so many aspects of their operation they failed to attain what was necessary. Within the context of Canadian health care, accountability involves “the obligation to answer to an authority that conferred a responsibility, by an agent who accepted it, with the resources and delegated answer necessary to achieve it, and with the understanding that inadequate performance will result in intervention.”8(p27) To achieve or ensure accountability, it is essential to achieve clarity about expectations, methods of assessing performance, answerability and consequences for non-compliance.

With respect to the first requirement, clarity about expectations has been a moving target. When RHAs were established in the early 1990s, the overriding
consideration was reducing health-care expenditures as part of a broader political agenda of deficits and debt reduction. Not surprisingly, most RHAs were initially saddled with the unpleasant task of downsizing the health sector and facing the ire of affected stakeholders, from health-care providers to the general public. But by the late 1990s expectations shifted from deficits and debt reduction to efficiency and effectiveness, a development that made some RHAs (those sparsely populated and rural) vulnerable to claims that they themselves were inefficient. Accordingly, most jurisdictions underwent a reduction in the original number of authorities and some eliminated RHAs altogether.

When it comes to measuring performance in Canadian health care, “there has been a mish mash of ‘indicators’, ‘targets’, and ‘benchmarks’ suggesting confusion over the nature and goals of the performance management regime.”9(p39) Issues of access to reliable and comparative data, methodology, and usability have all come into play. This has been partly the result of attempting to enhance accountability to stakeholders while providing managers with performance improvement information, two distinct audiences with different requirements. What is often reported is either incomprehensible or not useful for the average member of the public. The broad nature of regionalization and the complex environment within which regions operate “make it difficult to develop valid, reliable and consistent evaluation criteria to measure the ‘success’ of the RHAs.”10(p412) This environment has been also a reflection of the politically contested values underpinning the choice of performance measures in health care. Often because of public pressure, measurements related to access to acute care outweigh efforts to measure outputs or quality of care. In the end, performance measures have become politicized and thus subject to criticism and neglect.

The answerability of RHAs for performance has also been problematic. Performance targets not met do not automatically result in budget reductions or other consequences. For example, the complexity of wait times makes assigning blame a challenge.9(p46) While in some jurisdictions CEOs now sign performance contracts with annual performance bonuses, the track record of assigning consequences to not meeting performance targets is spotty at best. This does not mean that ultimately a provincial health minister cannot fire RHA boards and/or senior managers. However, there is no apparent connection between performance measures and these sorts of events.

Concern over the lack of responsiveness has not been limited to general accountability. It has also been tied to the effort of making local citizens part of the governance structure and participating directly in decisions about health priorities and allocation of resources. As with accountability, the evidence on citizen involvement of this type has been conflicting, but does suggests that the regional agencies have struggled to meet expectations. The intentions behind the agencies were certainly positive, but the effects were less so. Take, for example, the act of regionalization itself. It did amount to a redistribution of authority and influence away from the central ministry of health towards communities and
the new boards. But at the same time it involved in most provinces reducing several hundred local boards to several dozen regional agencies, which in turn meant fewer formal opportunities for direct citizen input into local health care decision-making.

While provincial governments initially sought to involve citizens by making them members of the governing structure (usually a combination of provincially appointed and locally elected members) most jurisdictions backed away from local elections because voter turnout was extremely low and research on the attitudes of elected and appointed board members showed little difference in opinions about accountability. Also relevant, one national survey found in almost all provincial jurisdictions that less than 50 per cent of respondents felt accountable to local citizens, suggesting that citizen governors failed to appreciate that an important part of their role was to be responsive to the citizenry in the region. A further point to consider was evidence suggesting that the community appeared to have little interest in being decision-makers. At most, they only wanted to be consulted and to leave the actual decision-making to those more expert in health care matters.

Part of the struggle with involving citizens directly in governing could also be traced to the way in which accountability is structured in Canadian health care. Despite political rhetoric about making health care decision makers more responsive to local communities, formal accountability of RHAs was totally upwards to provincial governments. In addition, there was and remains no single accountability relationship for health care. Regional health authorities are formally accountable to provincial governments and feel informally accountable to various professional and lay constituencies. More to the point, it has been clear that while board members may state that they feel accountable to local constituencies when something goes wrong in health care, Canadian citizens (and health professionals) are more inclined to turn to their provincial governments for a solution than some new and ill-defined regional body. Provincial governments have not hesitated to remove regional health boards when they have failed to meet the expectations of their provincial political superiors.

If the intention of provincial governments was democratic empowerment through regional health authorities, by traditional standards the results have been less than stellar. However, as with other aspects of health care reform, governments were also interested in supplementing initial ways of thinking about citizen participation with new ones. The concept of community engagement, which involves receiving information from government, being consulted by government, and actively engaging with public officials, has been a growing focus since initial experiments with elected boards were abandoned and the whole notion of citizen governance given less emphasis. Interestingly, the evidence shows that boards have been able to achieve instances of effective community input through consultation. But it is still possible to add up the
various disappointments with this form of public consultation and observe that engagement of the citizenry has achieved little success. Participants have felt that consultations were little more than “window dressing” and amounted to exercises in which government pursued “hidden agendas.” The negatives of community engagement also included the presence of apathy among community participants, a citizenry ill-equipped to consider the complexities of health care, and a sense of frustration arising from the negligible impact of consultations on government decisions.

A major rationale for establishing regional health boards was to make health care decision-making more responsive to wishes of local community members through an effective regime of accountability and citizen input into decision-making. As mentioned earlier such a regime requires clarity in relation to expectations, methods of performance measurement, answerability, and penalties for non-compliance. Regional health authorities have fallen well short in establishing clarity in all of these areas, though not entirely through their own actions. The same fate has befallen regional health authorities in their attempts to achieve greater citizen participation through both representation on boards and exercises in citizen input. The failure of participation through election or appointment to boards occurred largely through lack of citizen interest, shifting provincial priorities and the inability of boards to insert themselves effectively into the health decision-making process. The limitations of exercises in community engagement became apparent because of poorly designed input opportunities and citizens without the capacity or willingness to be active participants.

**Service Delivery and Integration**

A second rationale for regional health boards was the integration of administrative and service delivery, with an emphasis on the coordination of health care services to increase the continuity of care. This coordination or integration could refer to a number of actions, including sector, agency or service partnerships, mergers, or amalgamations to facilitate more integrated care. More commonly, the term refers to the coordination of heretofore relatively separate entities to “allow people to move more easily through the health system.” As with accountability and citizen participation, it is possible to list a set of activities in relation to integration but to do so is to create a more positive effect than in the case of accountability and public participation. As Church and Smith note, “Regionalization [has] allowed for a greater degree of ‘system thinking’ and recognition that better health could be achieved through integration of care....” One instance of integration at work is the heightened use of nurse practitioners, who serve to provide greater connectivity between services. Regional health authorities have employed this type of nurse to help facilitate the establishment of various practice settings in the area of primary care.
A further instance is RHAs working with medical associations and provincial departments of health to connect isolated general practitioners with other services to form networks of primary care and related regional health services.\(^26\) Home care is another area that has experienced some integration.\(^27\) The most prominent actors in the regional arrangements, hospitals, have as well acted to integrate services to provide more efficacious care. For example, the Alberta Cardiac Access Collaborative functions to ensure that patients with heart problems can traverse the relevant parts of the system without confusion; the collaborative initiates the “patient journey” with treatment for the heart attack, shifts the patient to follow-up with general practitioner and specialist, and then makes available any necessary surgical care and rehabilitation.\(^28\) The payoff here is reduction in wait times, better care, and greater continuity of service. A similar study shows that integration efforts have been employed to reduce the time between heart attack and actual treatment through the construction of an efficient “transfer pathway,”\(^29\) and stroke patients have also been the beneficiaries of integrated stroke care systems.\(^30\)

Integration across more than one sector of health care has permitted authorities to contend with the frustrating problem of elderly hospital patients blocking access to beds because of a failure to locate care for them in long-term facilities. Emerging regional solutions have included hospitals and coordinating agencies in the community working together to provide alternatives to nursing homes, allowing seniors to vacate hospital beds.\(^31\) A number of other integration actions directed at patients who impede access to hospital beds have been taken and the problem has been the subject of intensive examinations.\(^32,33\) Individual RHAs have also acted on their own to introduce an impressive set of integrative efforts to enrich quality of care,\(^34\) and it is suggested that RHAs may be the appropriate administrative vehicle for developing ambitious arrangements which encourage seamless care by combining the financing of hospital, physician, and community care into single payment methods.\(^35\)

The foregoing instances of integration suggest that regionalization can be seen as having taken “a firm step” towards a more continuous-care health system.\(^7(p85)\) But problems remain in this area, which make it difficult to conclude that integration has been a success. One is the issue of long wait times that arise largely from a lack of integration. A recent national survey of wait times suggests that there is significant variation within health services and across jurisdictions.\(^36\) Thus, despite reports of success, integration of service delivery through health regions does not yet appear to have measured up to what was promised. Another problem lies with the decision in all provinces to deny regional health authorities responsibility for physician service budgets. The result of this decision is that RHAs are without a player absolutely essential to turning the primary-care system into a truly integrated system of care. Integration is also stymied by a lingering sense of inter-board rivalry that results in an unwillingness of boards to share innovative service-delivery ideas. Finally, authorities in
some provinces are without the clear authority and necessary resources to carry out successful integration exercises. Integration can be a disputatious process and one that demands a great deal of time and effort – qualities requiring little doubt about whether regional health agencies have the required authority and the personnel to carry out the task. At the extreme, this problem turns into a political issue where provincial governments over-rule regional authorities for the sake of gains unrelated to the health of citizens. In Ontario, one of the health authorities put forward an integration plan for a set of inter-related hospitals that proposed consolidating some services and converting others in the name of efficiency and financial stability. The plan received the approval of the regional board and a respected external consultant; however, the planned changes proved unpopular in the public sphere, especially with citizens most directly affected by the adjustment of services. The health minister initially indicated her support of the initiative and resisted demands to set up an independent review of plan. But eventually the minister announced that an additional external assessment would be conducted. The integration plan had been thoroughly reviewed, given a stamp of approval by one of the province’s most respected hospital administrators, but this had failed to impress the provincial government.

As noted above, the evidence shows that the provinces have acted on the aim of making it easier for patients to move through the health care system. But this same evidence reveals both frustration with the lack of integrated services and the existence of regional health care systems without the authority to address the problem of health services existing in near isolation.

Community-Based Care and Cost

A third intent of RHAs has been to spend less on institutional care and more on community-based services. Community-based care usually includes home health services (such as nursing, diet counselling, occupational therapy), home support services (personal care, meal preparation, and home help), and community care services (shopping, transportation, community dining). The first two types of community-based care are typically combined and called home care services, and they are focus of this paper. Home-care services are favoured by governments because research suggests they can produce substantial benefits. These benefits include addressing the issue of bed-blocker patients through the provision of post-acute care services; delaying or preventing admission into long term care facilities; allowing seniors to maintain their independence longer; and saving money because home care is less expensive than institutional care. With all these advantages, it is easy to appreciate why RHAs and provincial governments are indeed interested in emphasizing home care over traditional health services such as hospital and long term care.
All provinces have increased the availability of home care services, thanks in part to federal funding targeted at this area. Some provinces have also set up special programs which give priority to home care – for example, the Aging at Home program in Ontario and Alberta’s Aging in the Right Place strategy, both of which work to keep seniors in their homes. The question, though, is whether the increase in home care spending has effected a change in the allocation or shares of overall health care spending by provincial governments (and territorial ones). While the data remains imperfect, estimates suggest that shifting of resources to home care has been modest at best. During the period 1994/94 to 2003/04, home care spending expressed as a percentage of total government health-care spending in the provinces and territories rose from 3.1% to 4.2%. More up-to-date percentages are less precise, but attempts at providing such data show only slight movement; during the period 2004/05 to 2010/11 the percentages varied between 4.2% and 4.5%, with the latest one at 4.4%. A more generous estimate of home care spending achieved through a re-interpretation of the data might be appropriate, but this would be insufficient to cause spending shares for home care to move upwards very much (ranged from 5.0% to 5.8%).

As with much of the efforts of regional health authorities, the best that can said about the shift to community-based care is that attempts have been made to lessen the dependence on institutional care but that these have had a negligible effect. To be sure, the earlier discussion of initiatives directed at relieving pressure on hospitals by the provision of more health choices in the community demonstrates that there is promise in the bid to change how we think about the provision of health care. But at the same time, this bid has been in play for such a long period (easily preceding the advent of regional health authorities) that it can only be disappointing to see how little distance has been traversed. It might be argued that the lack of success with the shift follows from the earlier disappointments outlined in the previous pages. What is needed to address this continuing challenge is increased responsiveness to public pressure and more service integration, especially the latter because integration efforts more clearly reveal the deficit in community-based care. However, it has to be understood that health providers in the institutional sector have traditionally been uncomfortable with a significant reallocation of existing resources.

The examination of home care leads to the last concern to be considered, namely health expenditures in the provinces (and territories). The failure to produce any major shift to less expensive care leads one to predict that attempts to deal with rising overall provincial and territorial health expenditures probably have had little impact; this prediction is indeed correct, up to a point. Total provincial and territorial health expenditures from the middle of the 1990s to 2010 recorded an average annual growth rate in constant dollars (2002 dollars CDN) of 4.5%. One result of this was the health care portion of provincial and territorial total spending increased, from 27.5% in 1995 to just short of
In some respects, this analysis is unfair to the RHAs because they are responsible for only about two-thirds of the entire health care budget, with two major contributors to cost – physicians and prescription drugs – being outside their authority. But the chief service under the control of health authorities, hospital care, has experienced an average annual growth rate for 1995-2010 of 3.9%, which is similar to total provincial and territorial expenditures. Accordingly, up until 2010, the data suggest the RHAs have done little to help stem growth in provincial and territorial spending on health care. However, the average annual increase over the most recent period (2010-14) for total provincial and territorial health care spending was only 1.0%, and the comparable figure for hospital spending was almost the same, at 0.9%.

On the issue of costs, then, it seems that RHAs have enjoyed some belated success with this attempt to lower rates of increase in spending on health care by provincial governments. But the overall story is that the regional bodies have for the most part been unable to curtail fairly high growth rates in spending on health by the provinces and territories. Moreover, the fact that increases in government health care spending have slowed quite dramatically in areas outside the control of the RHAs and even outside of Canada suggests that larger social and economic forces might be responsible for the greater control of health-care spending in more recent times.

Regionalization Reversal

Regional health authorities have struggled to address the major limitations of health care in Canada, but arguments can be made – some suggested in this paper – that appropriate measures might be able to turn failure into some degree of success. However, the reversal of regionalization in Canada and elsewhere may indicate problems that resist solutions because they are embedded in any attempts at decentralization in health care. In the case of Alberta, it is argued that rivalries between regions, missed opportunities to realize economies of scale in relation to purchasing supplies and even the delivery of services, and differential access to services in the health regions explain the demise of the regional authorities. The recent demise of regionalization in Nova Scotia is also explained by competition between the regions and a “splintered” health care system that offers differentiated sets of services to residents. In Europe, a number of countries (Norway, Denmark, Sweden, Finland, and United Kingdom) have acted to re-centralize their health care systems for similar reasons to those in Canada, suggesting that common problems do in fact attend attempts at health-care regionalization; it also suggests the intractability of problems that hinder regionalization. A reason for the reversal in Europe that has not gained notoriety in Canada is that the application of information technology has “reduced the transaction costs of information and made it feasible to
more closely monitor health system performance from a central level.**48(p105)
This development strikes at the heart of the case for decentralization in health care because it suggests that proximity to services is not necessary to achieve accountability in government.

The factors behind de-regionalization also reflect more general concerns relating to the operation of government programs. One is the belief of political officials that NPM should be seriously questioned because it is difficult to measure the performance of public initiatives like regional health authorities; added to this is the recognition that there is little incentive in government to put forward evaluations of public programs for fear of having to explain less than positive findings. Problems with NPM and measurement of program outcomes have led to calls for a return to the old practice of ensuring bureaucrats follow set procedures, a proposal that would most likely bring about the dismantling of arrangements such as RHAs.3 Senior political officials also feel that authority ought to be brought back to the centre in order to better manage the “turbulent environment” in which governments now find themselves.49(p183) A less deferential populace, a mushrooming of agencies dedicated to assessing public programs, and the 24 hour news cycle are only some of the factors contributing to the turbulence and a consequent reluctance to allow the autonomy associated with well-functioning regional health agencies. It is felt that a failure to heed this movement towards the centre leaves governments too vulnerable to forces that may serve to discredit those in office.

In examining the forces pushing towards reversals of regionalization, it is important to recall that no public activity is without trade-offs. RHAs do induce or fall victim to problems whose seriousness warrants the considerations that can cause the end of regionalization. But regional authorities bring with them the potential for new benefits such as a more integrated set of health services and a health system with a greater reliance on community-based care. The reversal of regionalization in various locales serves to remind us that regionalization has its problems, but the potential of regional health agencies counsels us not to give up too easily on this important experiment in health care reform.

**What to Do?**

The foregoing pages have largely been concerned with the shortcomings of regional health authorities in Canada. There have been a few bright spots, but mostly it has been a matter of documenting the inability of RHAs to meet their major objectives; the paper has also had to concede the demise of regionalization in some of the provinces.50 The issue now becomes whether actions can be taken to put these organizations on the right track. The paper has shown the difficulty of establishing the requirements of accountability in relation to the citizenry, and this same citizenry seems uninterested in electing their own members to regional boards or participating in engagement exercises. The problem of legitimacy also
arises as citizens and health professionals bypass RHAs to gain better decisions from provincial officials. The efforts of regional boards directed at service delivery and integration of services to provide a greater continuity of care have been hampered by a lack of authority over physician care, provincial government interference and a failure to sufficiently diffuse innovations across RHAs. And these problems in turn have hindered attempts to produce a health care system with a more community-based orientation and a greater capacity for cost control.

The problems affecting regional health boards and the consequent attempts to ameliorate these problems point to the necessity of two immediate actions. One, as Lewis and Kouri write, is that “[g]overnments must decide, finally, what regionalization should be, and then leave the regional health authorities to get on with the job, fully accountable for performance.” Following this advice resolves the confusion over the locus of responsibility, limits end-runs and provincial intrusions into board activities, and builds up the legitimacy of the boards. It also emphasizes the need for satisfying accountability requirements, especially the need for workable and understandable performance measures, and forces the provinces to confront the problem of the lack of board authority over services essential to their success. Implicit within this issue is also the need for regional health authorities to address their own problems, which include insensitivity to results of citizen engagement exercises, failure to share new ideas and innovations with each other, and a less than aggressive approach to establishing integration and continuity of care. Interestingly, at least one provincial government in Canada already appears to be moving in the direction of greater decentralization of health services, with new legislation being introduced to provide for the transfer of major responsibility for primary care from the central Ministry of Health to health authorities. Moreover, Ontario regional health authorities have achieved some limited success in the areas of integrated services, patient engagement, and hospital wait-times, suggesting that there is indeed potential in bringing the planning and management of health care services closer to those providing and receiving such care.

A second required action is that “a new and open conversation with the public [about health care] must be established.” For Lewis and Sullivan, the conversation is mostly about giving full information to the public about the Canadian health system so that they can understand and support the need for necessary reforms. This would certainly apply to the regional health boards, where the absence of information sometimes allows powerful players to secure their own interest over the public interest. A conversation would also give the public (and patients) a chance to voice their frustrations with exercises in community engagement and gaps in service delivery. But the conversations about the regional health boards could also be seen as the first step towards a larger conversation about the Canadian health care system and the consequent construction of a new vision of the system and the place of RHAs within this re-invigorated system.
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