

## Notes from the Editor-in-Chief

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HEALTH AUTHORITIES have been in place in developed countries such as Britain, New Zealand, Sweden and other European countries for several decades, and global wisdom would suggest that this is one area where Canada could learn from others' experiences. However, Canada's health system has several unique characteristics which may make the direct applicability of other countries' experiences a considerable challenge. For example, one of the main differences between Canada and some other countries is the clear delegation of authority by the federal government to provincial governments; provincial governments have responsibility and accountability for the organization and delivery of health services. Another distinguishing factor is that Canada is the only developed country that has a public system without formal recognition of a private-sector provision of services.

Because of the provincial mandate for delivery of services, nine of the Canadian provinces, the exception being Ontario, have chosen to experiment with some type of regional health authority. Each provincial government has delegated to local authorities different types and levels of accountabilities for the health and health services provided to a given population. Regional health authorities then have assumed responsibility for the health of a population and some but not all types of health services in a given region. The regions have been defined by the geographic area covered by the authority or the size and characteristics of the population being served. Other types of health authorities have been formed with province-wide responsibilities – for example, for the delivery of the full continuum of services for a particular population such as those with mental health problems, persons with cancer or those with cardiac problems.

While provinces have assigned different responsibilities to health authorities, there are some common themes. In theory, regional health authorities are held accountable for the quality of health services in their region. For example, they may manage and operate hospitals, community health centres, home-care programs and different types of long-term care facilities. Health authorities may be accountable for hiring physicians, nurses, laboratory technicians and other health professionals needed to deliver services. They may inspect restaurants or investigate environmental problems affecting public health in their community. In establishing health authorities, the general responsibilities have included promoting and

protecting the health of people in their region and preventing disease and injury; setting priorities for health services and allocating resources; ensuring reasonable access to quality health services in their region; and providing health services in a manner that focuses on the needs of individuals and communities, and integrates services across their regions.

The expectation was that regional health authorities would ensure greater accountability by providers to payers and communities being served; clarify roles and responsibilities and accountabilities of all players, including providers, provider organizations and consumers; define a clear role for government in terms of responsibility for central policy, standard setting and monitoring performance; improve decision-making about resource allocation and population health needs; ensure consumer and other community groups participate in the decision-making, with faster responses to local community needs; increase ability to measure system performance at a regional level; develop more reliable and valid measures for each region of access, costs, quality and outcomes; and encourage the development of regional benchmarks to facilitate a comparison of regions within a province across a range of health indicators. A tall order!

From time to time there has been much speculation about whether or not regional health authorities or regionalization has been working across Canada. It was therefore with some trepidation that *HealthcarePapers* approached Steven Lewis and Denise Kouri to ask if they would be willing to write the lead paper on the Canadian experience with regionalization of health services. Lewis and Kouri agreed to this task, and their paper has formed the basis for some lively discussion. Their paper addresses four main questions. First, what is regionalization in healthcare, and what distinguishes it as a structure? Second, how was regionalization intended to contribute to the achievement of the goals for the health system articulated in the 1980s and 1990s? Third, how has regionalization been implemented in Canada – its formal configuration, the degree of flux and stability and the “rules of the game” – and how have these factors affected its potential to achieve its intended impact? Fourth, with the experience gained over the last decade, how might we now (re)design regionalization to better contribute to health system goals?

Lewis and Kouri’s analysis indicates there is no agreement on a definition of regionalization in healthcare but that Canadian regionalization has four main characteristics: first, regions are defined by geography – they occupy specific territory; second, their existence and authority are defined by the provincial government rather than

being self-defining entities; third, they have consolidated at the regional level the authority previously distributed among many programs and communities; and fourth, they are responsible for a considerable range of health services, including community, long-term care residential and acute care services, and often extending to mental health and addictions, public health and health promotion.

The authors conclude that regionalization is still primarily a structural change, and attainment of health goals depends on provincial commitments and mandates. The provinces have wavered in their commitment to attaining health goals, partly because they realize that they are not meaningfully held accountable for them. Governments have proven vulnerable to pressures to slow down the pace of reform and paper over problems with money – hence the 42% growth in total spending between 1997 and 2003. As implemented, regionalization is a quintessentially Canadian measure. At first glance it appears radical and bold, but on closer inspection it has been incremental and constrained. Local programs and in some cases communities lost some authority, while governments retained more than met the eye. Neither governments nor the public have seemed ready to fully embrace the new entities and give them free rein. In some instances, governments have repatriated some of the authority previously devolved.

The authors also conclude that there appears to be less fragmentation in the system, less duplication of services in hospitals, and that admission to long-term residential care is more streamlined and needs-based. There are intersecting partnerships that probably could not have been developed without regionalization. Some regions are vigorously pursuing primary healthcare renewal. Lewis and Kouri state: “To succeed, regionalization needs a clear mandate, committed partners, outstanding leaders and a vision that will mobilize providers and the public. Government must decide, finally, what regionalization should be, and then leave the regional health authorities to get on with the job, fully accountable for performance.”



**“ In healthcare, structures don’t “do” anything ... they can provide a directional nudge to the system and create the potential for major change.” page 14**

The issue of regionalization is still of great interest and debate both in the nine provinces with formal regional health authorities as well as in Ontario, where a different pattern of authority distribution has been used. The commentaries on the lead paper reflect this interest and are both thoughtful and informative. We begin with the thorny issue of funding allocation methodology provided by Hurley of McMaster University, one of Canada's leading experts on this issue. This commentary provides information on the various methods used to develop fair and equitable methods for resource allocation to the regions as well as within the regions. Population needs-based funding has met many challenges and is still in its early stages.

Next we go to Quebec, which is the province with the longest experience with regionalization in Canada. Denis, Contandriopoulos and Beaulieu, from the University of Montreal, present regionalization as an opportunity to meet broad ideals of democratization as well as leading to health improvement at local levels. Levine, of the Régie régionale de la santé et des services sociaux de Montréal-Centre, stresses the importance of regional health authorities in providing leadership and management of integrated service delivery. Davis, president and CEO of the Calgary Health Region, provides a practical perspective of what it is like to manage a regional authority. He believes that discussion of regionalization needs to place patient care at its core and that regionalization is an evolutionary process and perhaps always changing to meet the needs of the community. From the perspective of Nova Scotia, Ward, former Deputy Minister of Health and Bedford, Associate Deputy Minister of Health, agree with the concept of evolutionary systems and speculate that to achieve a new vision for healthcare in Canada will take more than a realignment of organizational structures. Tomblin, of Memorial University in Newfoundland, recognizes that regionalization is potentially a tool of government but that it can challenge the very traditions and cultures of the government itself.

In our cross-country tour, it would be unfair not to stop in Ontario – the province that has been considered the “control case” because it has not introduced formal health authorities. It is not that Ontario does not have regional structures in place through its district health councils, which have planning authority; but one of the key issues that has not been resolved in Ontario is the lack of clear definition of what constitutes a “region.” Professional associations, district health councils, public health units and the government itself all have different geographic boundaries to their regional bodies. From the Ontario perspective, we begin with a commentary from Flood and Sinclair, renowned for their critical analyses of the

healthcare scene in Ontario. These authors describe the continuing opposition to the idea of regional health authorities by many local hospitals and community services boards and professional bodies. The provincial government has therefore chosen not to focus on devolution but upon accountability through various forms of performance measures. Sullivan, Dobrow, Thompson and Hudson, from Cancer Care Ontario, describe new developments by their organization to integrate service delivery for cancer patients at the regional level. They agree with Lewis and Kouri that to succeed, regionalization needs a clear mandate, committed partners and outstanding leadership to make it happen.

Finally, we move to an international perspective. Dwyer writes from her viewpoint as chair of a governance and funding task group on comprehensive health system review in South Australia, one of Australia's eight states and territories. She describes similar struggles in Australia to those experienced in Canada. Casebeer discusses the situation in the United Kingdom, where arguably regional health authorities have been in existence in some form for over 50 years, and helps us to see regionalization as both a practical and research opportunity. Rather than focusing on the specific provincial, Canadian, Australian or British contexts, we should be seeking out transferable lessons.

In closing, let me thank Lewis and Kouri for providing the lead paper to stimulate this interesting discussion. As they indicate in their response to the commentaries, this is certainly a provocative topic. In spite of some special projects in a few provinces there has been little progress in integrating primary health care (or for that matter most medical services) under the umbrella of regionalization. It is difficult to envision much progress until greater attention and commitment is made in these areas. In spite of all the discussion, the take-home message from across the provinces seems to be that there is still no one best way to structure; it depends on a complex set of social, political and other environmental factors. Clearly, like any other health reform, the governments of the day must show their commitment to making the change happen – this usually means providing adequate resources, and perhaps more importantly walking the talk!