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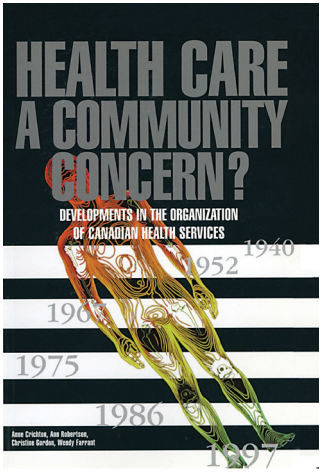

HEALTH CARE: A COMMUNITY CONCERN?
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
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CHAPTER 29

Regionalization

Towards the end of the 1980s four strong pressures were forcing the provincial governments to think about organizational change in their health care systems: (1) the continuing reduction in transfer payments from federal government; (2) urgent questions about improving the efficiency and effectiveness of health service organization; (3) the shift in emphasis on goals from health care access to improving health status outcomes which has led to a reconsideration of the weight put on biomedical care (the need for a social model of care if outcomes are to be improved was accepted as a national policy in 1989); (4) the need to consider how best to increase community concern about individual and community health, so that lifestyle and environment issues could be addressed earlier and more continuously rather than waiting until disease struck. New human rights policies have also emphasized the need for attitude change towards greater individual responsibility and more concern for good community network supports.

It was thought that effective reform and restructuring could be achieved by bringing health services "closer to home," setting up regions which would be able to find savings by bringing together the traditional divisions in the system which had been kept separate in the provincial health departments; regions which would be able to develop health promotion ideas and would bring in community members as policy decision makers and partners in networking. But regionalization has taken many different forms across Canada so it may be useful first to consider what the provinces were changing from and changing to in developing this restructuring.

From Functional to Areal Decentralization

Mills and Vaughan (1987), who studied decentralization for the World Health Organization (WHO), distinguished between functional decentralization and

areal decentralization. In functional decentralization, authority is transferred for performing particular functions in a particular service to a particular local office (e.g., mental health); in areal decentralization, health care is likely to be one social service among many, all of which are expected to work across limited geographical boundaries.

Until now most of Canada has had functional decentralization in its health care system.[1] Doctors negotiated with the medical plans, public health had separate budgets from continuing care and mental health, and hospitals made claims on their own divisions within the health departments. Drug and alcohol services might be funded through separate commissions. Each of these separate sections set up its own hierarchies in each province.

In the late 1980s and early 1990s provincial commissions of inquiry into health services identified a number of ways in which reforms could be brought about, and it was generally agreed that there should be a shift to areal decentralization of health services. This seemed to provide a mechanism for restructuring which:

1. Would cut across the existing divisions within the system
2. Would enable a shift of emphasis between acute care and community care to be more readily accomplished
3. Would permit local community representatives to become involved in policy making
4. Would increase the public's interest in sharing scarce resources by focussing on real health needs (clarifying what are the determinants of health and ways to improve health status)
5. Would encourage greater concern within communities for meeting the special needs of disadvantaged groups
6. Would enable regions to work towards setting up community networking to provide support above and beyond that given by professional experts and administrators of social programs

Regionalization and areal decentralization were seen to be similar concepts. But Carrothers et al. (1991) think that there are differences which have not been recognized because the research community has failed to deal with the issue, that is, to consider organizational models to assist in the identification and analysis of policy process variables.

Carrothers et al. provide a historical account of regionalization of health services in Canada (or ideas about regionalization) beginning with the discussion of a paper (Canada 1974b) in which the federal government first showed its interest in the topic. But regionalization was of greater concern to

1 Quebec's plan being the exception.

the provinces than the federal government because they had to decide whether to let some of their power go to lower level authorities.

Decentralization

Before going on to look at the delegation of power to regions, it may be useful to consider some ideas about decentralization. In connection with its restructuring, Quebec wanted to discuss what decentralization meant (e.g., McGill University 1979; Lemieux and Turgeon 1980; Contandriopoulos, Laurier and Trottier 1986).

Writing a WHO guide, Mills and Vaughan (1987) distinguished four types of areal decentralization: (1) deconcentration, (2) devolution, (3) delegation, and (4) privatization.[2] These are defined by legal frameworks. However, according to these authors, while the legal definition of decentralization will certainly affect the degree of local discretion which may be utilized, there are many other influencing factors: "These include the control over resources, ability to mobilize political support, the perceived legitimacy of [the local members' position] and the general climate of rules, regulations and expectations within which they operate" (p. 13).

In 1992 British Columbia commissioned Hollander (1992) to prepare a paper on the advantages and disadvantages of decentralization. He identified the advantages as:

1. The reduction of regional disparities
2. Greater local input into decision-making
3. Greater overall democratization
4. Increased accountability
5. Better coordination and planning of services

The disadvantages are likely to be:

1. Poor conceptualization of goals and objectives
2. Poor fit between the objectives and the system devised to meet the objectives
3. The problem of the capture of local boards by those opposed to the provincial government
4. Possible strains in the exercise of authority between the provincial government and local boards
5. The need to rationalize two separate systems of geographic boundaries (i.e., hospital regional districts for capital planning and public health divisions based on school districts)

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2 See Appendix A for definitions.

Why Decentralize Now?

All provincial governments (other than Prince Edward Island[3]) had set up public inquiries into their health care systems during the 1980s (Angus 1991) and all of these, which had made earlier incremental changes, recommended reform and restructuring. (The Rochon report in Quebec [1988] encouraged the province to persist with its planned rational model brought in in the 1970s.) In most provinces the recommendations of the commissions or task forces had been to regionalize. The response of the governments to these recommendations was set out in Chapter 24, and most now began to move towards setting up regions.

Earlier Moves

Quebec's rational plan for structuring the health and welfare system of the province (Quebec 1970–72) proposed a four-tier system of Centres locaux des services communautaires (CLSCs), district hospital councils (DHCs), regions and a provincial government office. The emphasis was to be laid on consumer needs and consumer involvement in management at the point of entry to the system, the CLSCs. It has taken many years for the ideas to work themselves out because the technocrats in government were reluctant to delegate authority (Renaud 1984) and the service providers in CLSC management meetings dominated the consumers (Brunet and Vinet 1979). It is only in the last three years that the CLSCs have been governed by consumers alone and that the regions have been given any real authority.

Quebec has been settling down again after Bill 120 was passed. Recently, however, its regions have been given more authority over the district hospitals and community health centres (CHCs).

Elsewhere too, the provincial governments were not very willing to let power go.

Ontario

The Carrothers et al. (1991) study provided one explanation for these failures to address the issue of geographic decentralization. It said that governments had focussed on negotiations with existing service providers and had never looked at the system as a whole. But Ontario had set up a system of DHCs to advise the minister, following a public inquiry in 1974. Dixon (1981) has discussed these developments. At that time the government was not ready to delegate much authority to the DHCs, which were only expected to tender planning advice to the Minister of Health on priorities in their own

3 Prince Edward Island made a study of regionalization in 1995–6.

areas. The local members of DHCs are appointed by the provincial government. Each council is composed of forty percent providers, forty percent consumers and twenty percent local (municipal) elected officials. DHCs in Ontario are organized into six health planning regions across the province. Within each planning region, an informal, collaborative organization of the DHCs occurs, usually to address cross border service delivery issues.

Quebec and Ontario have compared notes on their progress in regionalizing from time to time, but progress was not rapid in either place as the central offices of provincial governments were not then ready to delegate much authority to these lower levels of decision making (Dixon 1981). Later studies of DHCs in Ontario (Sutherland and Fulton 1994; Quigley and Kealey 1990) have also shown the lack of good collective organization among DHCs at both the regional and provincial levels.

In 1991 the Ontario DHCs were given the task of annually viewing the operating plans of hospitals with respect to the service impacts for their communities. About this same time DHCs began to be involved in hospital restructuring plans. These events led to a heightened awareness of the DHC role in local planning. Concurrently the province set up pilot projects such as the Southwest Ontario Comprehensive Health System Planning Commission to explore regional planning and management functions. DHCs are being increasingly asked to take on regional planning initiatives. For example, mental health reform planning requires a regional planning component in addition to district or local level planning.

Are there too many authorities in Ontario which are confused about their roles and relationships? There is a planning department within the ministry which employs staff to delegate. The new government has not reappointed the Premiers' Advisory Council which worked alongside the provincial health ministry for years as a policy adviser on long-range health system issues. Neither seem to be able to communicate across the borders.

Regions exist but planning structures are informally organized and do not have formal legitimacy. The DHCs have no real control over the hospitals or the municipalities which provide a wide range of public health services, as their mandate is restricted to providing planning advice to the Minister of Health. The emphasis still seems to be on the biomedical rather than the social model of care in their planning process. Would it be better to set up a new structure (as Quebec did in 1971) or significantly restructure the existing one, rather than continue to introduce incremental modifications? Perhaps this is the wrong time to ask such a question when the whole social service system in the province is undergoing vast budget cuts and the unions are demonstrating fiercely against the neo-conservative policies of the government and any changes being made. The Omnibus Bill Legislation, 1995,

provides significant powers to lever hospital restructuring and changes in physician practice. This signals a major deviation from Ontario's incremental approach but centralizes authority provincially.

Other Provinces

It would appear that the main reasons for restructuring today are the deficits and debts of the public authorities who have felt forced to find savings in the health care system. As well it has been clear for some time that there is a need to change the emphasis away from acute care to community care and that devolving responsibility to local authorities for setting priorities could be the means to that end. Another reason is to involve community participants.

The Atlantic Provinces

The relative poverty of the Atlantic provinces has made them much more anxious to maintain federal involvement in health service funding and they have strongly supported the National Forum on Health. They have also been trying to convince the Ottawa bureaucrats that Canada Health and Social Transfers (CHSTs) should be based on need not on per capita calculations.

Richard O'Brien has provided a review of the current situation:[4]

Prince Edward Island

The province has been divided into five regions governed by community-based health boards replacing individual hospital boards. A community-wide needs assessment was completed for all five regions from 1995 to 1996. The report *Comprehensive Health* (Prince Edward Island 1996) is a directional piece which developed a comprehensive health model and further describes comprehensive health services and primary care. A second community health centre has been launched in the province. The actual delivery of community health services has not yet been changed, however. The Department of Health has been downsized and restructured as well. The program and operations functions have been transferred to a newly established crown corporation known as the Central Health and Community Services Agency. The Department of Health maintains responsibility for policy, research and evaluation functions.

Newfoundland

Newfoundland has moved to five broad regions for community health and eight regions for institutional services including hospitals, health centres and

4 Richard O'Brien, personal communication, March 1996.

nursing homes. All community health services are administered by the community health boards, and community health is responsible for health promotion, health protection, continuing care, mental health, drug dependency and public health. Under the continuing care program, a single entry system has been implemented that is based on a multidisciplinary approach to assessing clients referred for long-term care services, that is, home support which includes home management, personal care, respite, and long-term care institutional services. Employees of the Department of Health have been deployed to the regions and remaining staff in the department function as consultants.

New Brunswick

Eight regional boards replaced the original fifty hospital boards in 1992 with district, community and regional hospitals in a region under one board. From 1993 to 1994 the twelve family and community services regions were rationalized into seven regions to match the health regions (i.e., includes hospital corporations, mental health, public health and now family and community social services). The following community health initiatives have been introduced: (1) two community health centre (CHC) pilots are underway; (2) an Early Childhood Initiatives Program has been implemented and there are seventeen early intervention programs in the province; (3) the Healthy Active Living Program for Seniors promotes wellness including the prudent use of prescription drugs, nutrition, active living, and stress management; (4) a provincial breast screening program, targeted at women between the ages of fifty and sixty-nine, has been developed; (5) Telecare, a pilot toll-free telephone line staffed by nurses using a structure/computerized assessment tool, was established to provide advice and information to residents unsure whether a trip to the emergency room is required; (6) the public health mandate has been redefined, based on policy direction outcome-driven, targeted services, and partnerships, all reflected in core public health functions.

Saskatchewan

The most dramatic development took place in Saskatchewan. When the province was faced with bankruptcy in 1992 it was decided almost overnight to close fifty-two rural hospitals and establish thirty regional districts to determine how best to reform services in local areas for "rural depopulation continues unabated" (Lewis 1995).[5] Key elements in the plan were that municipalities should decide their own alignments; the province should develop a needs-based funding formula; that home care, long-term care and

5 S. Lewis, talk given to conference of University of British Columbia Health Policy Research Unit, November 1995.

acute care should be integrated under district authority; and that funds should flow away from and not toward institutions (Saskatchewan 1993a,b,c).

The first boards were appointed by the Minister of Health, but by 1995 the province decided that board members should be elected. Whether or not this was a successful democratic change is uncertain because a number of people with vested interests (e.g., physicians and unionized health workers) were elected. The turnout in elections was fifteen percent in cities and thirty to fifty percent in rural areas.

In the meantime further steps to devolve authority had been taken. Mental health, addictions and public health were transferred to districts. The provincial Health Department reorganized to provide support and a new data system is in process of development as are new evaluation methods. A committee to supervise quality of care has been set up (Lewis 1995).

Manitoba

Manitoba has not yet taken steps to regionalize but it is looking over the border to its close neighbour Saskatchewan. Meanwhile it has been giving strong support to a provincial inventory of biomedical facts and has established a pilot nursing research centre in Winnipeg.

Alberta

Alberta decided to move towards regionalization soon after the Rainbow report (Alberta 1990c) was accepted by the government, but the decision of government was to keep tight control over this process of deconcentration by centralizing decisions about any appointment of board members and expecting them to follow through on the government's ideas for change. The purpose of the government in the last three years has been to set fiscal targets in the seventeen regional authorities. In 1994–95 $86.3 million was cut, and in 1995–96 $25.7 million was cut, although the cut of $16.2 million which was forecast for 1996–97 has now been put on hold. This drastic approach to health care reform has resulted in great dissatisfaction among physicians, 138 of whom plan to leave the province. Health service workers have also gone on strike in protest and 78,000 members of the public have enrolled as Friends of Medicare.

"The government policy still supports a two tier system where private clinics are available for those able to pay. ... Since October 15, 1995 Mr. Klein's stubborn support of private clinics has cost the health system $420,000 a month in federal transfer payments." (Dier 1996, 4).

Dier is concerned that the community has been left out of the planning process. She has argued that: "There is an obligation for citizens, especially the better educated, to become informed and vocal about the direction and

process of changes that are radically altering our community. ... The public generally only acts when their personal life has been affected by the changes" (p. 5). She said that although it is reported that patient satisfaction remains high, "the use of proxy" indicators rather than outcomes to determine the quality of care is suspect" (p. 4).

British Columbia

British Columbia has been interested in the possibilities of regionalization since it was investigated by Foulkes (1973). Regional hospital districts had been set up for capital planning in 1966, but they were based on economic development planning regions while public health services were based on school districts, mental health services on their own logic and social service regions on theirs. Foulkes found it difficult to try to sort this out as did many successors in the health department (Miller[6]; Ryan 1984) or the British Columbia Health Association (Ruault 1992).

However, in 1993, following the Seaton committee's report on provincial health services (British Columbia 1991) the government decided to set up twenty regions. The province decided that its policy should be to seek more input from community members. One third were to be appointed by the minister from recommendations of neighbourhood groups, one third to represent special concerns (e.g., mental ill health, physical disability) and one third were to be professional experts on legal or financial matters. It is hoped that, in due course, board members will be elected, but it is probably too early yet as the public has not had time to become aware and engaged in the process of planning. British Columbia has set itself against any privatization and is endeavouring to make the public more concerned about the determinants of health and the need to link health care with other social programs, though this is still a long way off.

Development of One Regional Board in British Columbia

It may be useful to look at the struggles of one health region to come to terms with meeting its objectives. The Vancouver Regional Health Board (VHB) has been in existence for fourteen months at the time of writing (though it had a preparatory interim regional planning committee in existence for eighteen months before that to assess the challenges).

Capital funding is administered separately, and the VHB doesn't have any jurisdiction over clinical medical services (which are still administered by the provincial medical plan) or over subsidized pharmacy services (administered by provincial Pharmacare).

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6 James Miller, personal communication, 1981.

The VHB had to establish its own bylaws before the provincial government would consider making a budget available. Control over the budget is still to come. The VHB has reduced the number of hospital boards from ten to four and hopes this will make for administrative economies.

It is struggling with the fact that it has the main tertiary and quaternary care centres for the province, which are university medical school teaching centres, so it has to take a provincial as well as a local view. Some of these centres are taking in secondary level cases which should be treated locally (outside Vancouver), and so there is need to work out cross-border relationships with other regions.

The VHB is working on the development of a shared services corporation which will remove food, laundry, laboratory and other services from hospitals to a central service.

It is endeavouring to combine the work of the following community agencies: public health (which already includes continuing care), mental health, and drug and alcohol abuse services. It has inventoried the nongovernmental agencies with a view to eliminating overlaps and identifying gaps as and when possible, but it assumes NGOs (nongovernmental organizations) will continue to exist. Presently the provincial government is endeavouring to encourage amalgamations.

Six community health committees of up to fifteen members have been selected from the public resident in bounded geographical districts of the city. There are also subsidiary neighbourhood health committees. The community health committees have the responsibility for developing health plans for their areas and feeding these in to the VHB which will make a regional health plan. Seven population health committees have been set up to look at the special needs of seniors, persons with disabilities, multicultural groups and so on, and to feed this information into the VHB planning committee.

The VHB and the regional committees have been made well aware of the differences between richer and poorer geographic areas of the city and the special needs of less healthy people. They have been made very conscious of the determinants of health and are concerned about maximizing support services for those in need inside and outside their jurisdictions.

The board is working closely with a transition team of health service professionals recognizing that service providers will have to make the main adjustments to changes in the delivery process. This team has already identified many areas of savings.

A number of board and community health committee members have expressed interest in the idea of setting up community health or multiservice centres.

In the next four months it will be necessary to put together a health plan for the city so that budget adjustments can be made for the 1997–98 fiscal year. The community health representatives and members of population health advisory committees will identify issues which particularly concern them this year and will consider, as well, longer term plans for change.

Assessment of Regionalization

It was suggested at the beginning of this chapter that four strong pressures were forcing provincial governments to think about organizational change in their health care systems:

1. Reduction of transfer payments
2. Need to review efficiency and effectiveness of organization of services
3. Development of a social model of care
4. Greater concern about community participation

Regionalization may help to deal with the reduction in transfer payments by improving organizational efficiency.[7] It is clear that many provinces have not yet given regions the power to work right across the system to coordinate and integrate the whole range of services. They may advocate for a social model of care, but they have restricted mandates, restricted not only to health care but to some aspects of the health care system only. And as far as community participation is concerned, community members' inputs have been kept under tight control by the provincial governments, even in British Columbia which has been more committed to community involvement than many other provinces. The members can "advise and assist" in policy making but must steer clear of management activities. Researchers at McMaster University have been monitoring developments. Abelson et al. (1995) have raised questions about the willingness of community members to take total responsibility for making policy decisions and have found some hesitations in this commitment. However, Lomas, Woods and Veenstra (1995) surveyed board members in Alberta, Saskatchewan, Nova Scotia, Prince Edward Island and British Columbia and found that most were working very hard and were satisfied with their ability to influence local policies.

Summary

In response to four pressures on provincial governments: (1) reduction of transfer payments, (2) questions about efficiency and effectiveness of health service organization, (3) the implementation of the social rather than the bio-

7 A report by the Canadian College of Health Service Executives focuses on rationalization and cost control (CCHSE 1995).

medical model of care, and (4) the need for greater consumer involvement, a number of provinces decided that restructuring into regions was the way to go. The next part of the chapter discusses areal decentralization and its advantages and disadvantages. Then the discussion moves on to look at the pioneering of Quebec and Ontario in seeking input from lower levels of the system — Quebec's rational plan which was not put into full effect until recently, and Ontario's reluctant form of delegation. Next the more recent restructuring by other provinces is described, including some details about the work of one board in Vancouver.

Finally there is a brief assessment of regionalization as it stands at the present time. It is still somewhat limited in its mandates but it has brought community members into policy making.