Institute of Health Policy, Management & Evaluation
UNIVERSITY OF TORONTO

Regionalization: What can be Learned from Canada?

Gregory P. Marchildon, PhD
Ontario Research Chair in Health Policy and System Design and Professor
Institute of Health Policy, Management and Evaluation, University of Toronto

IV Conference of Brazilian Municipalities on Sustainable Development
Roundtable on Integrated Health Care: Are Regional Service Networks an Effective Option
Brasilia, April 24, 2017

IHPME

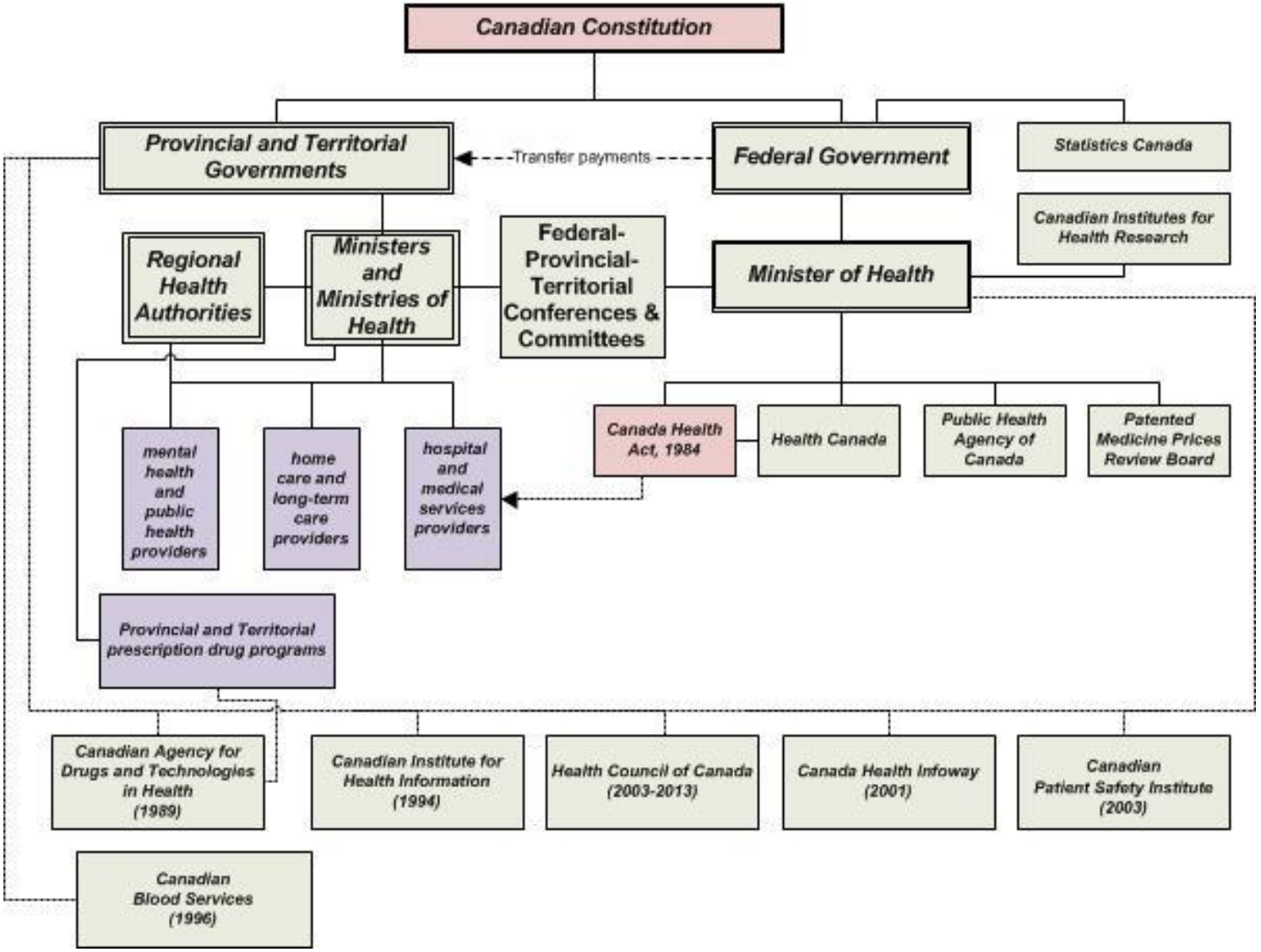
www.ihpme.utoronto.ca

Overview

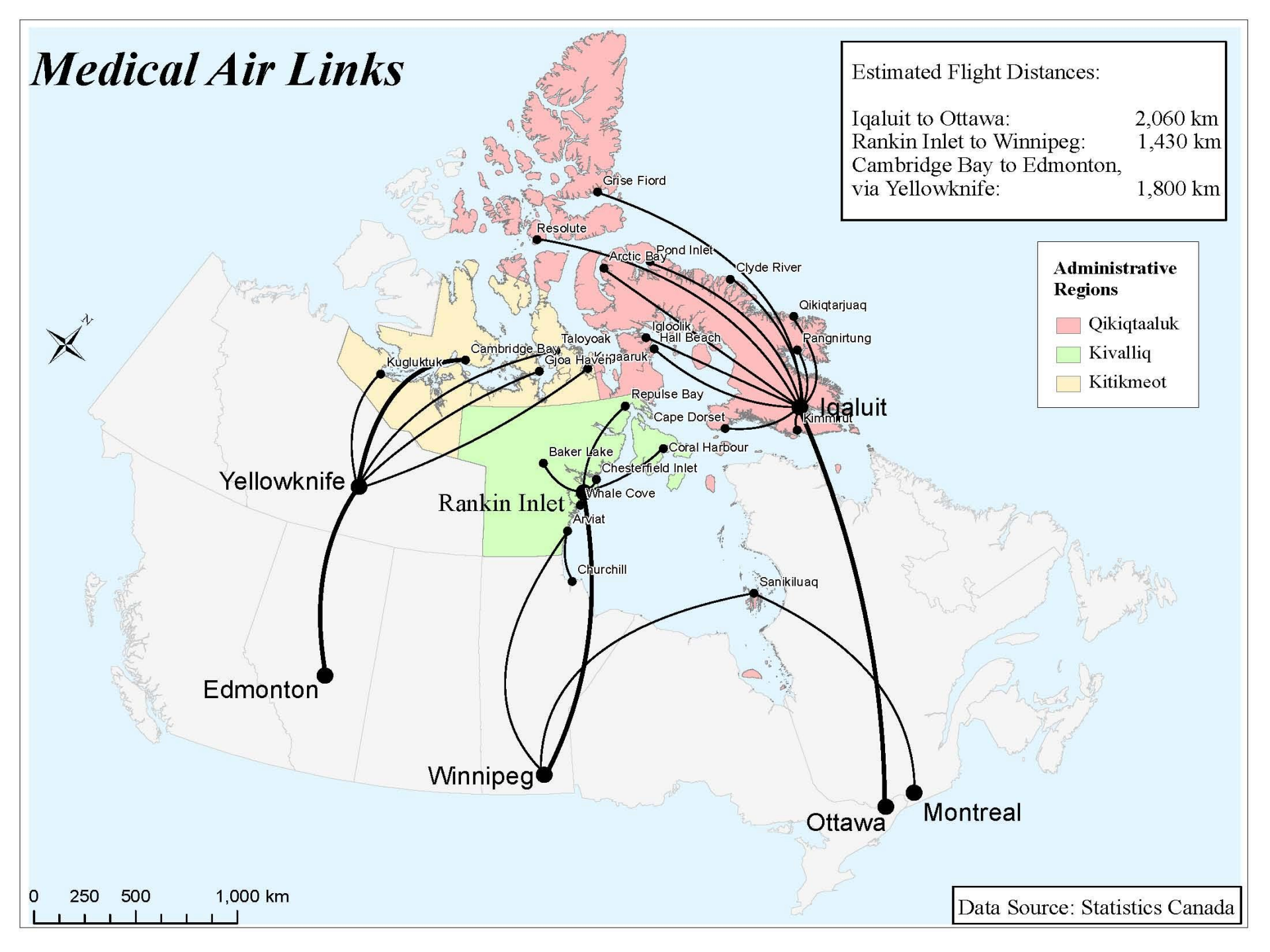
- Decentralization in Canada
- Objectives of regionalization
- Structure of regionalization
- Recent trends
- What do we know
- What we still not know
- Review of regionalized primary health care beyond Canada

Decentralized Federation

Decentralized Governance



Medical Air Links



Defining regionalization

- Definitions
  - "The integrated organization of a health-care system possessing multiple coordinated functions and serving a delimited geographical territory" (Castonguay-Nepveu Commission report, 1967)
  - "A Regional Health Authority (RHA) is a regional governance structure set up by the provincial government to be responsible for the delivery and administration of health services in a specific geographical area (Manitoba Centre for Health Policy, 2013)
- Three key concepts
  - Coordination
    - Mandate to manage previously fragmented health service organizations in a single system of coordinated (if not integrated) care
  - Decentralization
    - Authority to allocated budgets is moved from provincial health ministry to RHAs
    - RHAs have some governance and managerial autonomy from government / provincial ministry
  - Rationalization
    - Allocate resources in way to best meet needs and eliminate excess capacity

Regionalization and Health System Redesign

- Provincial health ministries as health system stewards
- Visible hand of management through arm's-length public organizations
  - Regional health authorities (RHAs)
  - Local Health Integration Units (LHINs) in Ontario
- New Public Management: separating steering from rowing
- Further division between regional health authorities and:
  - Some service delivery organizations including hospitals (Ontario)
  - Doctors (all provinces and territories)

Original Goals of Regionalization in Canada

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
4. Decrease variation and improve service quality through more evidence-based practices
5. Decentralize resources to facilitate a better match with population needs
6. Decentralize decision-making to encourage public participation and input
7. *Increase accountability by having RHAs report on performance and outcomes to health system funder and steward (health ministry)

Regionalization in Canada, 2015

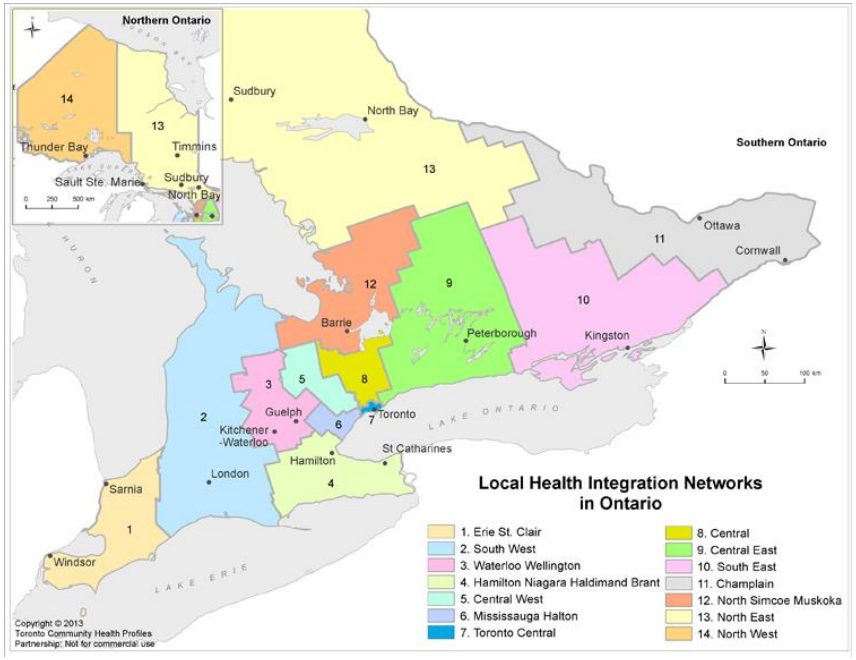
Jurisdiction	Population (millions)	Number of RHAs	Prior number	Name used	Year introduced
British Columbia (BC)	4.7	5	52	Health authorities	1997
Alberta (AB)	4.2	1	9 / 17	Alberta Health Services	1994
Saskatchewan (SK)	1.1	13	33	Health regions	1992
Manitoba (MB)	1.3	5	11 / 12	Regional health authorities	1997
Ontario (ON)	13.7	14	-	Local health integration networks (LHINs)	2006
Quebec (QC)	8.3	18	18	Regional health agencies	1989-92
New Brunswick (NB)	0.8	2	8	Regional health authorities	1992
Nova Scotia (NS)	0.9	1	9 /4	Nova Scotia Health Authority	1996
Prince Edward Island (PE)	(0.14)	1	5 / 6	Health PEI	1993
Newfoundland and Labrador (NL)	0.5	4	4	Health regions	1994
Northwest Territories (NT)	(0.044)	6	6	Health and social service authorities	1997
Yukon (YT)	(0.037)	0	0	-	-
Nunavut (NU)	(0.037)	0	0	-	-

Canada in the OECD Context of Regionalization

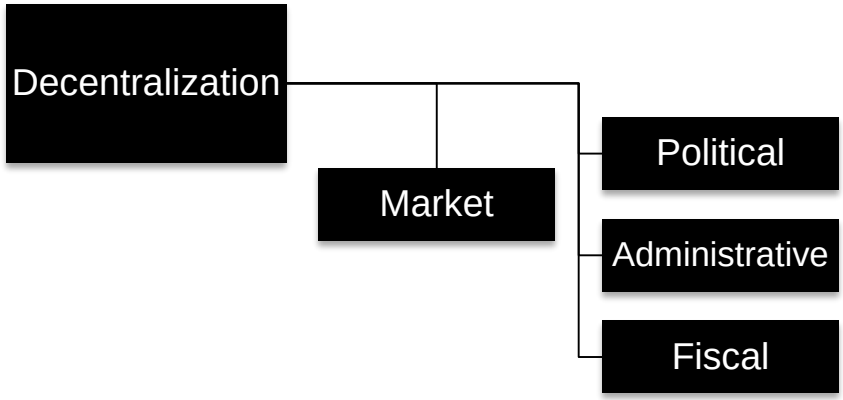
Structural Model	Features	Jurisdictions (abroad and in Canada)
Democratic decentralization	Political and administrative decentralization: regionalized units are also democratically elected bodies with responsibilities that extend beyond health care. Health services administered, regulated, coordinated and delivered by local governments.	**Sweden** (counties), **Spain** (autonomous regions), **Denmark** and **Italy** (regions)
Fiscal and administrative delegation	Statutory administrative delegation to organizations operating at limited arm's length from government. Health services administered, coordinated and, in some cases, delivered by delegated health authorities	**New Zealand**, **Australia** (NSW and South Australia), **United Kingdom** and Canada (BC, SK, MB, ON, QC, NB, NL, NT)
Administrative decentralization (with fiscal and managerial centralization	Bureaucratic deconcentration to executive teams located in geographic zones where health services continue to be delivered by centralized authority.	**Ireland** and Canada (AB, NS, PE)

LHINs Compared to RHAs

- Differences with RHAs in rest of Canada
  - Historically limited to coordinating
  - Size of population served served by most LHINs larger than most RHAs in rest of Canada
- Similarities with RHAs in rest of Canada:
  - Legislated mandate / delegated budget
  - Emphasis on geographic area served
  - Primary care excluded (except CHCs) but this may be changing
  - Contracting with service providers (service accountability agreements)



RHAs and Decentralization



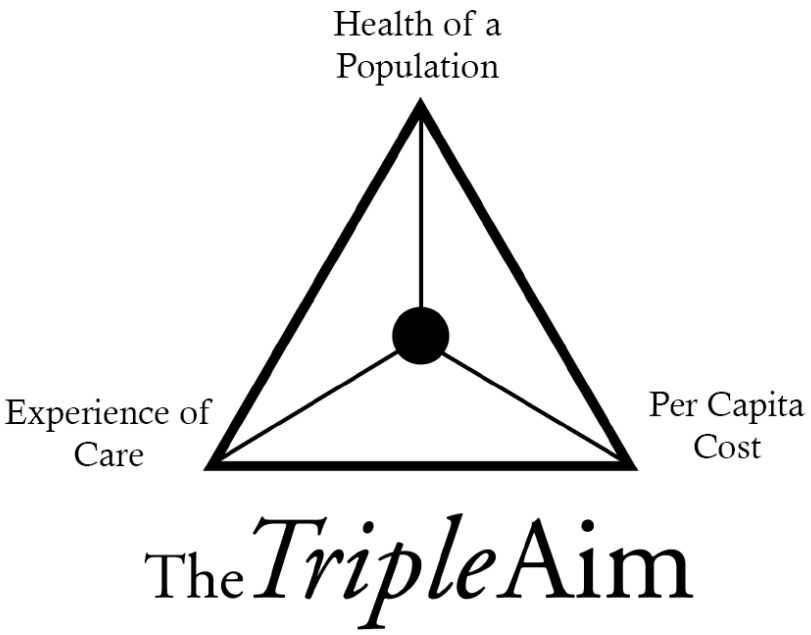
- Decentralization in the form of administrative and fiscal delegation
  - Mandate through legislation
  - Choice in budgetary allocation but may be more limited in practice)
- Creates stewardship and management functions that allows provincial governments to move from passive payer to active managers
- Except in Ontario, RHAs have direct ownership and control of hospitals
- RHAs have option to deliver services directly or contract (exception of hospital services in Ontario)
- But **bypasses local and municipal governments:** Therefore also implies a degree of **centralization**

Integration

- Main job of RHAs is to integrate and/or coordinate healthcare organizations
- However, existing silos of service delivery can persist despite system changes through regionalization
- Before regionalization, Canada did “not possess most of the basic characteristics of integrated healthcare such as physician integration and rostered population” (Leatt, Pink and Guerriere, 2000, p. 13)
- Organized delivery system defined as “networks of organizations that provide or arrange to provide a coordinated continuum of services to a defined population and who are willing to be held clinically and fiscally accountable for the outcomes and the health status of the populations being served” (Shortell et al.)
- Could be facilitated by – but does not require – common ownership

Bergevin et al. report on regionalization in Canada

(IPCDC and CFHI, March 2016)



1. Manage integrated, regionalized health systems as results-driven health programs
2. Strengthen wellness promotion, public and intersectoral action to address social determinants of health
3. Ensure timely access to primary healthcare and proximate services
4. Involve physicians in clinical governance and leadership, partner with them in accountability for results and engage with them in required changes in contracting and remuneration

What the Canadian Experience Tells Us

- Regionalization did not bend the health care cost curve
- But it did encourage greater investment in upstream care, prevention and population health
- It complexity of stewardship and management also increased:
  - Transitional risk of moving to more managerially complex organizational structure
  - Required new and sophisticated set of managerial competencies and leadership abilities

What We Still Do Not Know

- What is the optimal geographic and population size of RHAs?
- What is the correct division of roles and responsibilities between ministries and RHAs?
- What is the best way to provide financing to RHAs (e.g. population-based formulas)?
- Have we been able to use RHAs to shift resources to lower-cost but more appropriate care?
- **How can regionalization be used to make primary health care more central and integrative in health systems?**

Primary Health Care and Health System Redesign

- Effective primary health care common to all high performing health systems
- Point of first contact is like central nervous system in body
- Critical to effective coordination and integration
- Since 2002, Ontario has led way in terms of primary care reform – first step of a rostered population
- Primary Health Care Expert Advisory Committee (Price) report
  - Recommended physician integration through primary care fundholding groups (Patient Care Groups - PCGs)
  - PCGs would be accountable to LHINS
- Ontario did not go as far but LHINs now officially responsible for primary care

United Kingdom ➔ England (NHS)

- History
  - 1948 Implementation of NHS
    - local authorities stripped of health responsibilities – NHS
    - GPs retain autonomy but placed under capitated form of remuneration
  - 1973 - 14 RHAs established in England: allocated resources to 90 subordinate area health authorities
  - 1996 – 8 regional offices of the NHS Executive replace the 14 RHAs
  - 2006 – transformed into 10 strategic health authorities
  - 2012 – strategic health authorities abolished
  - Throughout GPs were independent contractors (unlike hospital-based specialists)
  - Recent Delegation of authority to Greater Manchester seen as possible regeneration of RHAs

- The Greater Manchester Experiment (DevoManc)
  - 2.7 million inhabitants
  - Began April 1, 2016
  - Budget (£6bn) for health and social care transferred to GM
  - GPs to become leaders of local care organizations (LCOs) running primary, community, social and mental health services
  - In a few years, GP services “will be fairly unrecognizable”
  - Partnership between providers, CCGs (12 clinical commissioning groups) and local authorities (10 boroughs)
  - Reboot both regionalization and idea of commissioning (e.g. primary care groups recommended in Price report)

Australia

- History
  - Early 1990s – Commonwealth government created Divisions of General Practice to support
  - 2011 – 120 DGPs replaced by 61 Medicare Locals to improve coordination and integration of primary care, address service gaps and be more responsive to patients
  - 2015 – Medicare Locals abolished in favour of Primary Health Networks (30 PHNs in country – much larger and more national reach
  - Each PHN to have a clinical council (led by GPs) that will be linked to hospital councils
- Current State
  - GPs receive 90% of pay through FFS financed through federal government (Medicare)
  - Also receive incentive payments for meeting RACGP standards re: IT, after-hours care, chronic disease management, mental health, etc.
  - Care coordination incentivized by Medicare for developing integrated care plans for complex needs patients
  - Incentives for including nurses in practices
  - Patient registration not required
  - Too early to determine impact of PHNs but trend has been to larger primary health care networks involving more sophisticated governance, management and linkages

Health Regions in New South Wales, Australia

New Zealand

- History
  - Early 1990s – most GPs became members of Independent Practitioner Associations (IPAs) to protect their interests
  - 1999 – district health boards (DHBs) to increase local involvement in healthcare planning and service delivery
  - 2001 – Primary health organizations (PHOs) were established to facilitate linkage with other local health services and improve coordination of care

- Current State
  - DHBs provide funding to PHOs (not the New Zealand government)
  - Most GPs are paid by salary (and so are hospital-based physicians) but work on contract: PHOs - DHBs
  - DHBs given a set of objectives by Ministry of Health but, like RHAs in Canada, have degree to autonomy in how they achieve these
  - Performance of DHBs is monitored by DHB Funding and Performance Directorate
  - DHBs governed by boards (up to 11): up to 7 elected by public in local government elections every 3 years; and up to 4 appointed by Minister of Health
  - Now 20 DHBs in New Zealand (recent consolidation)

District Health Boards in New Zealand

The Current Crisis of Regionalization in Canada

- Question of the value-added of administrative layer (boards + executive + staff)
- Division: political tier of provincial governments vs. managers and health policy experts
- Trend to centralization – consolidating RHAs in Nova Scotia, Northwest Territories and Saskatchewan into single agency
- Dramatic reduction in number of regional health authorities in other provinces (Manitoba and New Brunswick)
- Ontario is major exception – more authority transferred to current LHINs creation of sub-LHINs
- But no major, rigorous evaluations of the impact of regionalization