Regionalization in Canada:
Will Ontario become the new Ground Zero in Health System Reorganization?

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Summary

- Why focus on regionalization? Why Now?
- Definition, history and policy purposes
- Conceptual issues
  - Decentralization
  - Integration
  - Purchaser-provider split
- State of the nation in terms of regionalization
- Typology
- Establishment and nature of Ontario LHINs
- Ontario and future system change
Why Focus on Regionalization? Why Now?

- Most important policy shift since Medicare introduced
- Hall (1993): Paradigms, Social Learning and the State
  - Third order policy change (shift in the goals themselves)
- Policy consensus by 2006
- Less than decade letter consensus has evaporated
- Perhaps even crisis
- Challenge faced by decision-makers
  - Dissatisfaction
  - Lack of evidence
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: History of Idea

- **UK Dawson Commission**
  - 1920 report recommendation to deal with multiplicity of independent health facilities
  - Regionally-based organization to ensure continuum of services for defined population
  - Not introduced in NHS until 1974

- **Canada**
  - Henry Sigerist and 1944 report to Government of Saskatchewan
  - Conference of Ministers of Health
    - Task Force Reports on the Cost of Health Care in Canada (1969)
    - ON, QC, MB, BC, NS called for their own studies on potential of regionalization
  - Manitoba White Paper on Health Policy, 1972
Goals: as originally stated in public releases

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 RHA report on performance and outcomes to health system funder and steward (health ministry)*
Regionalization is complex combination of decentralization, centralization and a new managerial function

In Canada, health care is primarily a provincial responsibility: political, administrative and fiscal decentralization

Regionalization is really a form of administrative and fiscal delegation

But regionalization also implies a degree of centralization in terms of planning and in some cases (not Ontario) board governance

And creates new stewardship and management functions that allowed provincial governments to move from passive payer to active manager
Integration: Conceptual Challenge #2

- Main job of RHA 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).
- After regionalization?
  - Primary care and physician budgets
  - Hospitals and other institutional care
  - ICT systems and EHRs
  - Transparency and user responsiveness
Integration and 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.”
- Could be facilitated by – but does not require – common ownership
- Are RHAs succeeding as the main system tool to achieve an organized delivery system?
- How would you assess this?
  - Horizontal integration and coordination
  - Vertical integration and coordination
  - User satisfaction and responsiveness
  - Population health outcomes
NPM and Purchaser-Provider Split: Conceptual Challenge #3

- NPM: market-based reforms applied to public sector in order to improve delivery of public goods and services
- Went furthest in UK and NZ followed by US and NL
- Largely absent in practice in Canadian health reform but present in rhetoric
- Reason? Existing medicare system of “private practice and public payment”
- Compare this to NHS, a large, centrally-directed state bureaucracy
- Contrary to NPM, regionalization increased space occupied by public hierarchy but still many private actors
- Ontario’s form of regionalization formed an exception to this trend
  - Built in purchaser-provider split
  - But do LHINs truly buy services?
Regionalization: Implementation

- Fiscal crisis of early to mid-1990s
- Emphasis on cost saving through rationalization
  - Ontario achieved rationalization in another manner: Ontario Health Services Restructuring Commission
  - LHINs not introduced until 2006
- Considerable discussion of creating new wellness system
- But physician budgets never allocated to RHAs
  - No managerial direction over doctors working in RHAs
  - No effective control over primary care
# Regionalization in Canada, 2015

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Population (Q3 in 000s)</th>
<th>Number of RHAs</th>
<th>Prior number</th>
<th>Name used</th>
<th>Year introduced</th>
</tr>
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<tbody>
<tr>
<td>BC</td>
<td>4,683</td>
<td>5</td>
<td>52</td>
<td>Health authorities</td>
<td>1997</td>
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<tr>
<td>AB</td>
<td>4,196</td>
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<td>9 / 17</td>
<td>Alberta Health Services</td>
<td>1994</td>
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<tr>
<td>SK</td>
<td>1,134</td>
<td>13</td>
<td>33</td>
<td>Health regions</td>
<td>1992</td>
</tr>
<tr>
<td>MB</td>
<td>1,293</td>
<td>5</td>
<td>11 / 12</td>
<td>Regional health authorities</td>
<td>1997</td>
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<tr>
<td>ON</td>
<td>13,742</td>
<td>14</td>
<td>-</td>
<td>Local health integration networks (LHINs)</td>
<td>2006</td>
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<tr>
<td>QC</td>
<td>8,264</td>
<td>18</td>
<td>18</td>
<td>Regional health agencies</td>
<td>1989-92</td>
</tr>
<tr>
<td>NB</td>
<td>754</td>
<td>2</td>
<td>8</td>
<td>Regional health authorities</td>
<td>1992</td>
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<tr>
<td>NS</td>
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<td>9 / 4</td>
<td>Nova Scotia Health Authority</td>
<td>1996</td>
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<tr>
<td>PE</td>
<td>146</td>
<td>1</td>
<td>5 / 6</td>
<td>Health PEI</td>
<td>1993</td>
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<tr>
<td>NL</td>
<td>528</td>
<td>4</td>
<td>4</td>
<td>Health regions</td>
<td>1994</td>
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<tr>
<td>NT</td>
<td>44</td>
<td>6</td>
<td>6</td>
<td>Health and social service authorities</td>
<td>1997</td>
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<tr>
<td>YT</td>
<td>37</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NU</td>
<td>37</td>
<td>0</td>
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# Typology of Regionalization in OECD

<table>
<thead>
<tr>
<th>Structural Model</th>
<th>Features</th>
<th>Jurisdictions (abroad and in Canada)</th>
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<tbody>
<tr>
<td>Democratic decentralization</td>
<td>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.</td>
<td>Sweden (counties), Spain (autonomous regions), Denmark and Italy (regions)</td>
</tr>
<tr>
<td>Fiscal and administrative delegation</td>
<td>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</td>
<td>New Zealand, Australia (NSW and South Australia), United Kingdom and Canada (BC, SK, MB, ON, QC, NB, NL, NT)</td>
</tr>
<tr>
<td>Administrative deconcentration (with fiscal and managerial centralization)</td>
<td>Bureaucratic deconcentration to executive teams located in geographic zones where health services continue to be delivered by centralized authority.</td>
<td>Ireland and Canada (AB, NS, PE)</td>
</tr>
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Ontario and Origins of Regionalization

- SARS (2003) and exposure of system flaws, particularly silos in terms of hospitals, CCACs, community service providers and public health units
- Experience of regionalization in other provinces (ambiguous)
- Experience with integration in other areas (e.g. Cancer Care Ontario)
- Reality of powerful private NFP hospitals and influential boards
- Touted as a “made-in-Ontario” solution to creating an organized delivery system
- Focus on coordination rather than integration through ownership
- Plan discounted by some as “regionalization light” because of lack of ownership and authority
Nature of LHINs

- Limited to coordinating
- No “make or buy” decisions (no delivery role)
- Size of population served by most LHINs larger than most RHAs in rest of Canada
- Focus on performance measurement and management
- But also similarities with RHAs in rest of Canada:
  - Legislated mandate / delegated budget
  - Emphasis on geographic area served
  - Primary care excluded (except CHCs)
  - Contracting with service providers (service accountability agreements)
Performance of LHINs

- Unclear because no systematic evaluation of regionalization in Canada, much less Ontario
- Indeed, literature on regionalization has actually diminished since the 1990s
- Large system changes are notoriously difficult to evaluate because of:
  - Base line hard to establish
  - Impossible to hold all other factors constant (confounding variables)
  - Cost and administrative burden
  - Governments avoid potential embarrassment
  - Contextual differences in comparative assessments
- Nonetheless, essential to research and evaluate or intuition will inevitably replace evidence as basis of decisions
- Have great resource through CIHI which collates and disseminates data on regional basis
What does the future hold?

- Provincial ministries: health system stewards hold ultimate accountability
- 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
- MHLTC planning major system changes (Hon. Eric Hoskins, Nov. 4, 2015)
  - Clear that major structural change for system transformation is necessary
  - Care that continues to be “fragmented, disconnected and siloed”
  - Price report as powerful voice
  - Integrate CCACs into LHINs
  - “End-to-end integration” – hospitals and LTC?
  - “Stronger local governance. Greater integration”
Policy Options

1. Keep LHIN structure the same
   - Contract re: CCAC services
   - Use power of the purse in more ambitious way (as purchaser)

2. Turn into more conventional RHA structure
   - Still need to choose between highly centralized approach of single HMO with districts (AB, NS, PE)
   - Or more decentralized approach (BC, SK, MB, QC, NB, NL, NT)

3. Go further with integration than current RHAs
   - Fully integrated primary care
   - LHIN control over all physician budgets which it then redistributes to organizations who employ or contract with physicians
   - Or integrate fully through local governments instead of LHINs
Concluding Speculations

- Ontario is best position to proceed with deepening regionalization given primary care reforms
- However, provincial government faces powerful stakeholder interests who may benefit from lack of integration
- Raises question of whether LHINs will become owner-managers as well as funder-buyers
- How do you build leadership and managerial capacity rapidly to meet new responsibilities?
- Is the concept of the LHIN (or the RHA more generally) at all consistent with increasing local governance?
- What is the appropriate balance between ministry and LHINs: constructive tension between centralization and decentralization