Towards the Triple Aim of Better Health, Better Care and Better Value for Canadians: transforming regions into high performing health systems

March 2016
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ACKNOWLEDGMENTS
This study would not have been possible without the outstanding participation of the thirty senior health leaders from across Canada. A sincere thank you to each of them for taking time out of their extremely busy schedule and for their effort. Deep appreciation for their thoughtfulness in analyzing the major issues confronting health and healthcare across Canada, in contributing to identifying potential areas for improvement and in reviewing the draft report to validate the robustness of the findings.

Sincere thanks to the staff of the Canadian Foundation for Healthcare Improvement and in particular to Colby Williams for her tremendous coordination and follow-up and to Diane Hull for all her support.

The study received financial support from the Initiative sur le partage des connaissances et le développement des compétences (IPCDC) and the Canadian Foundation for Healthcare Improvement (CFHI).

A warm thank you to the staff of the Canadian Association for Health Services and Policy Research (CAHSPR) for making possible the presentation of the study at the Closing Plenary for the CAHSPR Annual Conference in May 2015.

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KEY MESSAGES

- Various forms of regionalization have been deployed over time and across provinces and territories in Canada. These diverse natural experiments have allowed for some progress, towards achieving the *Triple Aim* of better health, better care and better value but have yet to achieve their full potential.

- This study has been conducted against a backdrop of a lack of recent evaluative studies of regionalization and amidst efforts towards healthcare governance reform across the country. Its purpose has been to evaluate the impact of regionalization in Canada, specifically on the *Triple Aim*.

- The study has relied on a scoping review of the literature on regionalization and on 30 key informant interviews with senior Canadian health leaders.

- Results have revealed that, with the exception of Ontario, Canadian provinces and territories have moved towards a two-level system consisting of a policy level (Provincial/Territorial Ministries of Health) and a delivery arm (Health Authority or Regional Health Authorities). In such a system, the size of regional or provincial health authorities, both geographically and in terms of the size of the population they serve, can influence their successful functioning.

- Results also indicate that regionalization has contributed to some success in achieving better health, better care and better value, partly through the adoption of a population health approach, but that this success remains partial and variable across provinces and territories.

- According to the results of this study, the weaknesses of regionalization in Canada include: an incomplete results-driven program approach; a lack of role clarity between ministries and health authorities; an insufficient engagement of – and contracting with – physicians; the frequent reorganization in the structure and functions of provincial healthcare systems; weak information systems; and the insufficient financial coverage of essential drugs in ambulatory and home care settings.

- And yet, the greatest promise of regionalization may be the capacity to manage health systems so as to achieve the integration of a comprehensive array of services for a territorially defined population.

- Such a population-oriented integrative capacity could enable regional leadership to manage resources, opportunities and constraints so as to achieve the *Triple Aim*.

- To be able to act as effective “integrators”, regional health authorities ought to possess a management capacity to implement provincial policy orientations while having sufficient incentives and leeway to adapt to the specificities of the regional and local contexts.

- As a way forward, the study proposes seven areas for improvement which, when implemented should contribute importantly to the *Triple Aim* and do so with modest one-time costs and important recurrent cost savings:

  1. Manage the integrated regionalized health systems as results-driven health programs transforming them into high performing health systems
  2. Strengthen wellness promotion, public health and intersectoral action for health to better address the social determinants of health
  3. Ensure timely access to personalized primary health care/family health and to proximity services
  4. Involve physicians in clinical governance and leadership, partner with them in accountability for results and engage them in the required changes in physician contracting and remuneration
  5. Engage citizens in shaping their own health destiny and their health system
  6. Strengthen health information systems, accelerate the deployment of electronic health records and ensure their interoperability with health information systems
7. Foster a culture of excellence, learning, innovation and research and encourage adaptive capacity towards continuous quality improvement

It is our belief that when these areas for improvement are implemented, then our vision for regionalized high performing systems in Canada can be achieved, leading to significant strides in the Triple Aim of better health, better care and better value.
EXECUTIVE SUMMARY

The study of the regionalization of the healthcare systems in Canada is both important and timely. The purpose of this report is to provide insight and evidence on the impact that regionalization across Canada has had on the Triple Aim of Better Health, Better Care and Better Value.

Major findings are discussed, a vision of the future of regionalization in Canada is presented together with a way forward including seven areas for improvement, which, when implemented should lead to major progress towards the Triple Aim; these should incur modest one-time costs and should contribute to major recurrent savings.

This study used a rapid evidence-based approach, including structured interviews of 30 Canadian health leaders from every province and two territories (response rate 94%). These included deputy ministers, assistant deputy ministers, two former ministers, CEOs of regional health authorities (RHAs), academics (including one dean), and leaders from Canadian health organizations. Respondents were ensured anonymity of responses, which allowed them to express themselves frankly and freely. In addition to the interviews, a scoping review of the literature on regionalization in Canada over the past decade was conducted, as was a rapid review of the characteristics of some high performing health systems in other countries.

This study presents several strengths: the senior positions, expertise and experience of the interviewed health leaders together with their very high response rate (94%); the convergence of the findings from the interviews with those from the literature; the consistency of the findings across Canada; and the systematic validation of the findings by study participants when the draft report was circulated for validation and feedback.

Throughout this study, several factors made it difficult to tease out cause-and-effect relationships and to separate out the contribution of regionalization to overall improvements in health and healthcare. These included: the lack of relevant healthcare performance data disaggregated at the regional level and the weakness of current information systems; the absence of formal evaluations of regionalization across Canada and in many cases the lack of meaningful annual reporting on performance; the multiple changes in the structure, functions and numbers of regions that have occurred since the beginning of regionalization across the provinces, thus precluding an observation period sufficient to draw satisfactory conclusions; the fact that much of the literature is in the form of expert opinion and lacks quantitative evidence; and the lack of a true comparison group, although some would argue that Ontario, not having formally regionalized, could act as a comparator.

Regionalization in context

Canada ranked 10th among 34 OECD countries in 2008 with a life expectancy of 80.7 years; Japan ranked first, with two years more, at 82.7 years. The life expectancy of Canadians has increased nearly 3 years in the past seven years, testimony to rapid progress. Canada could further improve its life expectancy through a) of a stronger focus on population health, public health and intersectoral action towards healthy behaviors, prevention of non-communicable diseases and addressing the social determinants of health; and b) by increasing the performance of its health systems. Canada compares unfavorably among OECD countries in four measures highly valued by Canadians: 1) out-of-pocket expenditures for health; 2) timeliness of appointments with a doctor or nurse; 3) access to after-hours care; and 4) overuse of emergency departments.
In the United States, high performing health organizations such as Kaiser Permanente and Intermountain Healthcare can provide many useful lessons for healthcare across Canada. The need to learn from such high performing American organizations was raised by many of the senior leaders participating in the study.

**Major findings**

**Towards a two-level system**

Recognizing the usefulness of regions, there has been a convergence of regionalization models across Canada with most provinces moving towards a two-level system in which the ministry of health provides policy, financing and overall governance and oversight, and Regional Health Authorities (RHAs) are responsible for regional governance (in line with provincial policies), management and service delivery for a given territory and population. Ontario is the notable exception across the country. Ontario’s system is structured between a two-level and a three-level system. The province has maintained local hospital boards, has a strong focus on access and quality, and has instituted Local Health Integration Networks (LHINs), which carry out certain integration and coordination functions but are not regions in the true sense of the word. The two-level system has proven very functional in several provinces including British Columbia. As of April 1, 2015, Québec has moved to a two-level system as well.

**Optimal size**

Several study participants expressed the view that the size of regions is important for their functioning. A population size between 350,000 and 500,000 was deemed optimal, with road travel times within the region not exceeding three to four hours. This is consistent with the approach recommended by the WHO and other multilateral agencies. Different services are optimally organized and delivered on different scales and thus to different population sizes: local for primary health care, regional for secondary care and provincial for tertiary care.

**Better Health: better than before but variable and partial**

There was a strong consensus among study participants that regionalization has contributed positively – albeit variably – to improving the health status of Canadians through an enhanced population health approach with better care, strengthened public health and an intersectoral approach to address the determinants of health. Regions act as integrators towards health improvement (figure below). However, the potential contribution of regionalization had not been fully realized.
**Better Care: better than before but variable and partial**

Regionalization has contributed to improved care through enhanced knowledge of the needs of communities and populations; an evidence-based approach to the provision of care; the development of needs-based regional service delivery plans; the regrouping of services for better quality, improved results and lower unit costs; and enhanced governance and managerial capacity. Our study has revealed a more integrated and coordinated approach to care with a better allocation of resources towards community, home and long-term care. Regional service delivery plans, specialist outreach and telehealth have additionally improved access to specialized services in the rural areas of regions.

**Better value: better than before but variable and partial**

Regionalization has often been implemented in the context of budgetary constraints; it is not evident however that regionalization per se has contributed to reducing costs. It can be said though that regionalization has contributed to enhancing the efficiency of the healthcare system. Examples include: rational and evidence-based regional service delivery plans better responding to the needs of communities; the reallocation of resources towards the community, ambulatory and long-term care; the regrouping of clinical services towards enhanced expertise, quality (reduced complications) and lower unit costs; the strengthening of primary health care including, in some cases, through the move away from fee-for-service physician remuneration; the reduction in management costs in some areas; and a long-term reduction in the pressure on emergency departments and hospitals arising from, on the one hand, stronger primary and community care, and on the other hand, from improving health status of the population through better care, enhanced public health and intersectoral action.

**Citizen engagement: both plusses and minuses**

The impact of regionalization on citizen engagement was reported to be mixed and at times more negative than positive. On the positive side, the enhanced population health and intersectoral approaches have increased attention to the needs of communities and facilitated dialogue with elected municipal officials and community representatives. Specifically, efforts have been made to engage indigenous peoples in the governance of their health systems, particularly in British Columbia and Quebec. On the negative side, the dissolution of hundreds of local hospital, health centre and other institutional boards through their consolidation into one RHA has greatly diminished the involvement of citizens in the governance of their health institutions.

**Incomplete results-driven program approach, with unclear goals, targets and weak monitoring systems**

Despite health expenditures of the order of $200 billion in 2014 (>6000 per Canadian, 11% of GDP), healthcare is often managed without the essential elements of a quality program approach: goals and objectives are often vague or absent, as are targets and baselines; monitoring systems are weak; theories of change and logical frameworks are incomplete; and emphasis on evidence-based interventions is variable.

**Engagement of physicians: improving, but variable and weak**

Although there has been important progress in the engagement of physicians as leaders, in clinical governance and in clinical networks, our study revealed very weak engagement of physician clinicians with regards to the health system, and regionalization in particular. Many study participants commented that the budget envelopes for physician services and for drugs – two very large components of health budgets and important drivers of the costs of the system – are not within the envelopes of RHAs. Most mentioned the need for far greater accountability of physicians for individual
patient outcomes, service utilization and system performance; in this context, many referred to the high performing healthcare systems, to the emerging results from accountable care organizations in the United States and to examples from other countries. The modes of engagement, contracting and remuneration of physicians was recognized by study participants as one of the major obstacles to improving the performance of the health system across Canada.

Patient-centered primary health care: variable across Canada and weak relative to other countries

Most study participants believe that this is a major issue facing provincial health systems, and regionalization in particular. Despite excellence in family medicine training in Canada and some well-performing family health teams in different provinces, access to primary health care and proximity services is variable across Canada and Canada’s performance is weak when compared to other countries.

Slow and variable progress on information systems and electronic health records

It was noted that there exist multiple health information systems, with major difficulties in exchanging relevant information between them. There is also an important variation in the rate of implementation of electronic health records, and the lack of interoperability between these and information systems precludes any real-time management of the health system. Several participants placed the Canadian situation in sharp contrast with that of Kaiser Permanente in the US with fully interoperable integrated information systems allowing for real-time management of individual patients and of the system, not to mention the mobile applications for patients who become partners in shaping their health destiny.

The frequent reorganization of the healthcare delivery architecture and of regional structures and functions within provinces

In several provinces, provincial governments have implemented changes to regional structures and functions every few years. While noting that some of these changes were necessary to improve function, these frequent changes – and poorly executed change management – have caused major disruptions to the system, taking precious time away from client-focused improvements in health service delivery in order to manage the changes. This has also prevented meaningful formal evaluations of regionalization.

Insufficient clarity in roles and responsibilities of governments/ministries of health and of regional health authorities

Study participants noted that over the past decade, functions have been devolved to RHAs without a commensurate readjustment within the ministries of health (absence of business process reengineering), often leading to duplications of function and to a tendency by ministries to micromanage regions. All study participants appreciated the need for oversight by an elected government. Most felt that the system performed best when the government remained at arm’s length from service delivery with clear communications between levels.

Inadequate financial coverage of essential drugs in ambulatory/home settings

Several study participants mentioned that the inadequate financial coverage of essential drugs in ambulatory care settings is a major roadblock to maintaining people in the community thus contributing to overutilization of hospital services and driving healthcare costs up. Many felt that
reimbursing the cost of essential drugs in all settings would in fact pay for itself, especially in the context of bulk negotiating and purchasing by provinces. This would greatly facilitate the work of RHAs to making further progress towards ambulatory, home and community care.

**Way forward: A vision for regionalization and seven areas for improvement**

**A Vision for Regionalized High Performing Health Systems in Canada**

Based on our findings and study team deliberations, a vision emerges for high performing regionalized health systems and for territories where healthy public policies can be implemented. The realization of this vision rests on re-establishing and respecting the clarity of the respective roles and functions of provinces and regions, and on ensuring the accountability of the health system’s various players (figure below).

This vision reflects recent developments in health policy in high performing health systems around the world, including Accountable Care Organizations in the United States. Furthermore, if one were to combine the best characteristics of health regions across Canada, one would likely achieve such a vision. Such a vision is thus realistic in the near term for Canadian provinces and territories (figure below).
The governance function of regions is particularly important to ensure an optimal adaptation of programs and resources to the specific needs of communities and characteristics of regions, as well as to meet the realistic expectations of key stakeholder groups. Regional governance is also necessary for regions’ efforts to engage and involve citizens and elected officials in health-related issues.

Regional health authorities should be held accountable for implementing their multi-year health plan and program. This regional plan and program should have clear goals, targets, baselines, benchmarks and a strong monitoring system. It should include the following components: service delivery (with physician human resource planning), public health and intersectoral action.

The following seven areas for improvement can lead to major, rapid progress towards the Triple Aim.

1. **Manage the integrated, regionalized health systems as results-driven health programs transforming them into high performing health systems**
   With clear goals and objectives, targets, baselines, milestones, robust monitoring, transparent accountabilities, all supported by strong, real-time information systems.

2. **Strengthen wellness promotion, public health and intersectoral action for health to better address the social determinants of health**
   Given the important potential health gains related to this approach, foster healthy regions through wellness promotion during clinical interactions, enhanced public health and intersectoral action that engages citizens in shaping their health destiny, and their elected municipal officials in improving population health.

3. **Ensure timely access to personalized primary health care/family health and to proximity services**
   Re-emphasize the local level and timely access to multidisciplinary family health teams responsive to clients’ needs:
   - with modern appointment systems resulting in timely appointments, extended hours and on call services
   - using a team approach fostering continuity and integration of care
   - that focuses on maintaining autonomy with patients at home and in the community thus reducing the recourse to emergency rooms and hospital care
   - focusing on high quality, effectiveness and efficiency, including through team work and supervised delegation
   - through a relevant performance-based contracting system fostering on the above attributes

4. **Involve physicians in clinical governance and leadership, partner with them in accountability for results and engage them in the required changes in physician contracting and remuneration**
   Building on recent progress in clinical governance, physicians should be much more involved as leads for clinical services and be held accountable for results of the clinical services they lead. Clinical governance in this case is optimally achieved by physician leads/co-leads who display strong leadership and who foster motivation and teamwork. Strengthening quality of care and clinical excellence would also require the further development of strategic clinical networks that connect individual clinical services within and across regions.
   Beyond that, individual clinicians should be held accountable for their patients’ outcomes and co-accountable for the performance of the health system. Modalities of contracting and
remuneration will need to reflect this new reality. It is to be noted that physicians in Accountable Care Organizations such as Kaiser Permanente and in other jurisdictions achieve a high level of professional satisfaction and remuneration commensurate with their expertise and workload under performance-based funding.

In this context, a strong argument can be made to regionalize budget envelopes for the remuneration of physicians, whether it is for family physicians operating within family health teams/centres, for family practice and specialist services in hospitals or for other specialized ambulatory services. Integrating physicians within regionalized structures and functions in this manner will ensure that integration reflects the notion of the production process within an organization, a key, but often neglected management principle.

5. **Engage citizens in shaping their own health destiny and their health system**

We will need to ensure that citizens are much more engaged in shaping their own health destiny in partnership with their health professional. Their engagement in the governance of their local and regional health system should likewise be fostered; they should also have the opportunity to participate in local citizen/patient committees linked with their community health teams/centres, as well as in intersectoral action for wellness and the prevention of non-communicable diseases and injuries. RHAs should also further strengthen patient advocacy and representation mechanisms at all levels of the system and further strengthen the dialogue with elected municipal officials and with other community representatives.

6. **Strengthen health information systems, accelerate the deployment of electronic health records and ensure their interoperability with health information systems**

In order to provide client-centered, integrated and coordinated care and improve the performance of the health system, electronic health records which feed a real-time population-based health information system should be fully deployed, as is currently being done in high performing healthcare organizations.

While this will require additional funding during the deployment and upgrade phase, such a system should greatly improve the efficiency of health service delivery, prevent duplication and unnecessary procedures, avert potentially dangerous drug interactions and support the maintenance at home and in the community of individuals who might otherwise end up in the emergency room and require hospitalization. All this should lead to recurrent cost savings, which should ultimately recover the deployment and upgrade costs of a full integrated electronic health records and information system.

7. **Foster a culture of excellence, learning, innovation and research and encourage adaptive capacity towards continuous quality improvement**

In order to foster excellence, the passion for care needs to be rekindled by involving and motivating health professionals and their professional bodies, and by fostering an approach of continuous quality improvement in all health service delivery and public health institutions. This will require effective leadership of ministries of health, RHAs and other health organizations, as well as nurturing a partnership with physicians in the context of enhanced accountability for results for their patients and the populations they serve. Accreditation mechanisms and continuous quality improvement strategies can contribute significantly to this effort. Provincial ministries of health should hold regions accountable for these results.

As knowledge is global, we should learn from the best of each system, both within Canada and internationally, and address the priority issues and areas for improvement discussed in this report. We should strengthen innovation and research programs which can contribute to improving the
Canadian health system. This can be achieved by addressing the issues and areas for improvement outlined in this report. We will need greater emphasis on and more investment in embedded research, closer to the delivery side, as well as in population health interventions, fostering a culture of learning systems.

Emerging high performing Accountable Care Organizations in the United States and elsewhere should be studied with the specific objective of learning what could realistically be applied to the Canadian healthcare context to bring about major improvements.

In conclusion, we believe that the proposed way forward, vision and seven areas for improvement can have a profound impact on the performance of Canada’s health systems within a few years, with a modest initial one-time cost and major long-term savings in recurrent costs. Such an approach would thus contribute to the Triple Aim of Better Health, Better Care and Better Value for Canadians. As a next step, we propose policy dialogues to discuss the findings of this study and the proposed way forward.
### ACRONYMS

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INTRODUCTION

Purpose of the report

Beyond the five founding principles of the Canada Health Act, regionalization constitutes de facto one of the main organizing strategies of health systems across provinces and territories in Canada (Government of Canada, 1985). The purpose of this report is to provide evidence and insight on the impact of regionalization across Canada. Major findings are discussed and a way forward is presented with a vision for the future of regionalization in Canada, together with seven areas for improvement. The authors hope that provinces, territories and the federal government review this report and work towards a practical, time-bound and targeted program of health system reform, with a view to achieving better health, better care and better value for Canadians within a few years.

Why study regionalization now?

The regionalization of health services has progressed at different rates across provinces. Québec was an early adopter, implementing regionalization together with universal health insurance in the early seventies. Ontario, on the other hand, has only recently pursued partial regionalization through its Local Health Integration Networks (LHINs). Over the past 20 years, there has been much experimentation with regionalization across Canadian provinces. These natural experiments were studied by the Canadian Observatory on Regionalization, which highlighted certain elements of regionalization with regards to the performance of provincial health systems (Lewis & Kouri, Regionalization: Making Sense of the Canadian Experience, 2004). Since 2004 however, there has been little systematic evaluation of the impact of the regionalization of health in Canada.

Interest in the healthcare services sector has recently shifted to managing for results and to continuous quality improvement. This is perhaps best exemplified by the high performing healthcare organizations (accountable care organizations) in the US and the recent decision of the US Government to transform Medicare physician re-imbursement from fee-for-service to pay-for-performance (Kaiser Permanente, s.d.; Steinhauer & Pear, 2015).

This report comes amid new announcements and undertakings of healthcare governance reform across Canada, such as the centralization of regional health authorities in Alberta, Nova Scotia and Prince Edward Island into one provincial health authority and Quebec’s recent shift to such a two-level regional system as of April 1st 2015.

These ongoing changes underpin the timeliness and importance of this report as it examines not only the impact of regionalization, but also discusses major issues at hand and presents a feasible and practical way forward and vision. This vision, if implemented, could have a profound impact on the Triple Aim of Better Health, Better Care and Better Value for Canadians, thus ensuring greater effectiveness and efficiency of health systems across Canada (Institute for Healthcare Improvement, s.d.).

District Health Systems / Regionalization

Following the Declaration of Alma Ata on Primary Health Care in 1978, national governments sought to implement primary healthcare for their populations with the support of the World Health Organization (WHO), and UNICEF for those countries in greatest need (World Health Organization, 1978). This has led to a body of work on district health systems with ministries of health appointing district health management teams for each health district covering a population of around half a million (World Health Organization, s.d.).
The World Health Report 2000 fostered an international discussion on the importance of improving the performance of health systems (World Health Organization, 2000). In its seminal 2007 publication *Everybody’s business: strengthening health systems to improve health outcomes: WHO’s framework for action*, WHO identified four objectives for a health system: improved health (level and equity); responsiveness; social and financial risk protection; and improved efficiency. It identified six building blocks: service delivery; health workforce; information; medical products; vaccines and technologies; financing; and leadership/governance (World Health Organization, 2007). The emergence of “regions” across Canada generally corresponds to the WHO’s definition of “districts”, which is the usual international terminology for such health structures.

**Regionalization in Canada**

Black and Fierlbeck define regionalization as “devolving the authority and responsibilities [such as home care and long-term care] from one governance structure to another” (Black & Fierlbeck, 2006). The provincial government controls funding and provides regions with adequate financial, human, technological and informational resources. In return, regions provide a set of services and are held accountable for the allocation of resources and for decisions made at the regional level. Over time, regions have also increasingly had to deal with issues such as funding shortfalls and governance-related ambiguities.

Each Canadian province and territory presents a unique case study in the implementation of regionalization, reflecting the uniqueness of each province’s or territory’s peoples, geographies, circumstances and political environments. Figure 1 summarizes the timelines for provincial and territorial implementation (Adapted from (Akunov & Verma, 2014) and updated for 2013-2015).

As Marchildon attests, all provinces except Ontario have undergone some degree of centralization of local health structures to regional health authorities (RHAs), thus moving to a two-level system consisting of ministries of health and RHAs. This has been achieved by dissolving the boards of local health institutions and placing these institutions under the RHAs (Marchildon, 2013). Over time, many provinces have also reduced the number of regions.
Figure 1. Regionalization Timeline across Canada, 1989-2015

Below is a rapid snapshot as of late 2015 of the current health governance situation in every province and territory. It is important to recognize that each of these thirteen jurisdictions is unique in terms of population size (from 13.8 million in Ontario to 37,000 in Nunavut), geography (from Victoria, British Columbia to Saint John's Newfoundland, around 5,000 km, and from the US border to the high Arctic, nearly 4,000 km), and peoples.

**British Columbia**

British Columbia’s healthcare system is governed and managed by eight entities. Under the authority of the Minister, the Ministry of Health leads the health sector in the province and is responsible for the overall governance, strategic direction, legislation, policies, and regulations of the health system. BC’s regional health authorities constitute five other, separate entities responsible, within their geographic areas, for the governance, planning and delivery of healthcare services to the province’s population of 4.7 million (Statistics Canada, 2015). The remaining two entities consist of the Provincial Health Services Authority and the First Nations Health Authority. These authorities span the entire province and therefore overlap with the geographical regions of the RHAs. The Provincial Health Services Authority works with the province’s five RHAs to coordinate and plan the provision of specialized services and provincial programs. It additionally manages and governs the organizations whose
responsibility it is to deliver these services and programs. The First Nations Health Authority, on the other hand, funds, manages, plans and delivers health programs to First Nations and works alongside the Ministry of Health, RHAs and Health Canada to enhance the accessibility, quality, delivery, cultural appropriateness and effectiveness of healthcare services and programs provided to First Nations (Government of British Columbia, n.d.).

**Alberta**

In Alberta, policy-making, legislation, and the setting of standards for the health system are within the authority of Alberta Health. This ministry is additionally responsible for administering provincial programs (e.g. Alberta Health Care Insurance Plan), allocating health funding, and providing expertise on infectious disease control (Government of Alberta, 2015).

Alberta Health Services (AHS), on the other hand, is the single, province-wide health authority in Alberta that is responsible for providing healthcare services to the province's entire population of 4.2 million. The authority was created in 2008 and replaced the province's 12 previous health entities (Alberta Health Services, 2015; Statistics Canada, 2015).

With the aim to improve healthcare in the province, AHS has additionally developed what are called Strategic Clinical Networks (SCNs). These networks are comprised of individuals who are knowledgeable in focused areas of health, such as addiction and mental health, cancer, seniors' health, surgery, diabetes, obesity and nutrition, etc. The SCNs are intended to achieve improvements and progress within these various specific areas of healthcare (Alberta Health Services, 2015).

**Saskatchewan**

In Saskatchewan (population 1.1 million), the strategic direction of the health system is overseen by the Minister of Health (Statistics Canada, 2015; Government of Saskatchewan, n.d.). Saskatchewan Health is responsible for overseeing and coordinating health service delivery in the province. The actual delivery of healthcare services is conducted by the province's 13 regional health authorities (or health regions) and the Saskatchewan Cancer Agency, either through healthcare organizations or directly (Government of Saskatchewan, n.d.).

**Manitoba**

Manitoba (population 1.3 million) currently has five regional health authorities that were amalgamated in 2012 from the previous 11 RHAs (Statistics Canada, 2015; Government of Manitoba, 2014; Government of Manitoba, 2013). It is the responsibility of these RHAs to oversee and manage the delivery and administration of healthcare services in their specified geographic regions. A Board of Directors is appointed by the Minister of Health for each RHA, and these boards are accountable to the Minister for the performance, resources and mandate of the health authority (Government of Manitoba, 2014; Government of Manitoba, 2013).

In the case of activities that are of mutual benefit to the various RHAs and that could occur on a provincial basis, Regional Health Authorities of Manitoba Inc. (RHAM), a non-profit corporation whose members consist of RHA CEOs, acts as an umbrella organization that coordinates the pursuit of such activities (Regional Health Authorities of Manitoba, n.d.).
Ontario

In Ontario (population 13.8 million), overall strategic direction, leadership, funding, legislation, policies, regulations and performance monitoring lie within the purview of the Ministry of Health and Long-Term Care (MOHLTC) (Statistics Canada, 2015; Health Care Tomorrow, 2014). In 2006, 14 Local Health Integration Networks (LHINs) were formed to better coordinate the responsibilities of healthcare delivery and administration from the provincial to the regional level. LHINs work to allocate funds to various providers in the region and work with the providers in planning and ‘decision-making’ at the regional level. The providers they are responsible for include hospitals, long-term care homes, Community Health Centres, Community Care Access Centres, Community Support Services, and Addictions & Mental Health Agencies, but exclude physicians, ambulance services, public health and provincial networks such as Cancer Care Ontario (Health Care Tomorrow, 2014).

Local health institutions (hospitals, etc.) have retained their boards, exercise considerable power and often maintain direct links to the MOHLTC. Therefore, LHINs cannot be considered full RHAs; Ontario can be characterized more as a three-level system (local, LHIN and Ministry) as opposed to other provinces which have for the most part a two-level system (Ministry/Health Authority).

Furthermore, public health falls under the responsibility of the province's 36 Public Health Units. These are official agencies established by rural and urban municipalities, governed by boards of health, and responsible for the administration of disease prevention and health promotion programs (Ontario Ministry of Health and Long-Term Care, 2014).

Quebec

Quebec only recently shifted its health system to a two-tier regionalized structure when Bill 10 was implemented in April 2015. The Bill eliminated the provincial health system’s middle tier by merging each region’s health and social services agency with its public institutions, giving rise to a single regional authority (Centre intégré de santé et de services sociaux – CISSS) for each geographic region in all regions except for the more populated ones of Montreal (5 RHAs) and Montérégie (3 RHAs). Nine of these RHAs are designated as Centre intégré universitaire de santé et de services sociaux – CIUSSS; these nine have formal linkages with one of Quebec’s four medical schools and have formal recognition of their academic mandate. With Bill 10, the total number of health and social services institutions thus decreased from 182 to 34.

These RHAs (CISSS and CIUSSS) are public institutions responsible for planning and delivering health and social services to Quebec’s population of 8.3 million; they are held accountable to the Minister for achieving province-wide targets and adhering to recognized standards of quality, accessibility, effectiveness, efficiency and integration. It is the responsibility of the Ministry of Health and Social Services, on the other hand, to set the province’s objectives, priorities and policy directions within the field of health and social services, and to ensure their proper implementation by these RHAs (Quebec National Assembly, 2015; Quebec Ministry of Health and Social Services, s.d.).

Newfoundland and Labrador

In Newfoundland and Labrador, the Department of Health and Community Services (DHCS) maintains responsibility for policy-making, priority-setting, program development, planning, and providing support to the province’s four regional health authorities, as well as to other mandated community service and health agencies. The DHCS additionally monitors these regional health authorities and agencies and provides them with feedback regarding health outcomes, accountability issues and program implementation (The Institute of Public Administration of Canada (IPAC),
Meanwhile, the four regional health authorities, which are led by a CEO and a Board of Directors, are responsible for planning, funding and managing services and programs in accordance with identified population health needs, as well as meeting performance objectives. They deliver direct care to the province's population of 528,000 through hospitals, emergency response services, healthcare centres, mental health and rehabilitation services, supportive care services (home care, long-term care, etc.) and community health services. They are accountable to both the public and the Minister of Health and Community Services for the expenditure of funds and the quality of provided services (Statistics Canada, 2013; The Institute of Public Administration of Canada (IPAC), 2013; MD Career Portal, n.d.).

New Brunswick

In 2008, New Brunswick's eight regional health authorities were amalgamated into two: Vitalité Health Network and Horizon Health Network. Each RHA is appointed a Board of Directors by the Minister of Health and is mandated to manage and deliver health services to the province's population of 754,000 (Statistics Canada, 2015; Government of New Brunswick, n.d.). These include the majority of Public Health Services, Hospital Services, Addictions and Mental Health Services, Community Health Centre Services, and Extra Mural Services. The services delivered by RHAs are offered in various settings, including hospitals (both on an in-patient or out-patient basis), schools, clinics, homes and other community settings. In addition to these RHAs, the Government of New Brunswick has established a public sector agency, Facilicorp NB, whose responsibility it is to provide a selection of non-clinical support services to the province's RHAs (e.g. clinical engineering, supply chain, information technology and telecommunications, etc.) (Government of New Brunswick, n.d.).

Prince Edward Island

Health PEI was established in July 2010 when the responsibility for delivering all publicly funded health services in Prince Edward Island (population 146,000) was transferred to this Crown Corporation and its Board of Directors (Statistics Canada, 2015; Health PEI, 2015; The Institute of Public Administration of Canada (IPAC), 2013). Health PEI is governed by a Board of Directors appointed by the Minister of Health and Wellness, and is run by a Chief Executive Officer. The Board is responsible for ensuring that health services and programs are delivered in compliance with the direction of the Ministry of Health and Wellness and does so by setting Health PEI's strategic direction, establishing governance processes and executive and organizational expectations, and monitoring performance (Health PEI, 2015; The Institute of Public Administration of Canada (IPAC), 2013).

Nova Scotia

In April 2015, Nova Scotia's nine district health authorities were merged into what is now known as the Nova Scotia Health Authority. This authority has partnered with the IWK Health Centre, which engages in research and delivers both primary, secondary and tertiary care services to women, children, families and youth. Together, IWK Health Centre and the Nova Scotia Health Authority plan and deliver healthcare services to the whole population of Nova Scotia (943,000) (Statistics Canada, 2015; Government of Nova Scotia, 2015). Like Alberta Health Services, the Nova Scotia Health Authority is comprised of several “zones” or areas.

Yukon

The delivery of health and social programs to Yukon's population of 37,400 is the responsibility of the Department of Health and Social Services (DHSS), which is advised by the Health and Social Services Council on issues of social services, health, justice and education (Statistics Canada, 2015; The Institute of Public Administration of Canada (IPAC), 2013; Government of Yukon, n.d.). Yukon does
not have a health authority. Yukon’s three hospitals are run by the Yukon Hospital Corporation (YHC), which provides the DHSS with a yearly report on operations. The YHC has established methods to deal with the health needs of Aboriginal peoples in the territory. As one example, the First Nations Health Program has been developed and is operated by Whitehorse Hospital. The program added to the hospital’s Board of Trustees a committee represented by a Council of Yukon First Nations, and has resulted in the development of First Nations-specific health initiatives (The Institute of Public Administration of Canada (IPAC), 2013; Government of Yukon, n.d.).

Northwest Territories

The major responsibilities of the Department of Health and Social Services in the Northwest Territories (NWT) include overseeing the territory’s healthcare system, setting healthcare priorities and policies, strategic planning, developing legislation, securing funding, and monitoring and evaluating the system that serves a population of 44,100 (Statistics Canada, 2015; The Institute of Public Administration of Canada (IPAC), 2013; Government of the Northwest Territories, n.d.). It used to work in partnership with the territory’s eight Health and Social Services Authorities (HSSA), which conducted the planning and delivery of health and social services to their respective populations, as well as the administration and day-to-day management of services and programs (The Institute of Public Administration of Canada (IPAC), 2013; Government of the Northwest Territories, n.d.). However, on June 4 2015, Bill 44 (An Act to Amend the Hospital Insurance and Health and Social Services Administration Act) was assented by the NWT Legislative Assembly. The Bill requires that the Minister of Health and Social Services amalgamate the eight HSSAs into a single, integrated territorial authority. This territorial authority is to be governed by a Territorial Board of Management that will be composed of the Chairs of Regional Wellness Councils and the Chair of the Tlicho Community Services Agency (Government of the Northwest Territories, 2015).

Nunavut

The Department of Health and Social Services in Nunavut (population 36,900) manages and delivers health services through a number of health facilities throughout the territory, including the Qikiqtani General Hospital in Iqaluit, health centres, and boarding homes. The services the Department provides include emergency care, primary care, mental health, family services, injury prevention and health protection and promotion. Given the size of Nunavut, the Department manages the delivery of these services through its three regional offices, located in each of Nunavut’s three regions (Statistics Canada, 2015; Government of Nunavut, n.d.; Nunavut Department of Health, n.d.; Director of Medical Insurance, 2012).
METHODS

This study used a rapid evidence-based approach consisting of a scoping review of the literature and key informant interviews with 30 senior health leaders from across Canada.

Scoping Review

The objective of the literature review was to acquire and assess evidence of the impact of regionalization across the country. A search strategy was designed to focus on regionalization in each of the provinces and territories across Canada and to focus on its impacts on better health, better care and better value. The designed search strategy thus consisted of a combination of keywords, including the names of provinces and territories, “Canada”, “health”, “regionalization”, “centralization”, “decentralization”, “de-concentration”, “integration”, and “devolution”. Once designed, this search strategy was used to search the Google online database. The search results were restricted by both language (English and French only) and date (post 2004, with the exception of a few key documents).

The described search strategy yielded peer-reviewed publications; documents on government laws and regulations; reports and publications; websites; newspaper articles and op-eds; and other relevant documents. Results of the online search were further supplemented by recommendations of documents provided during the key informant interviews. Over 250 documents were examined.

To place the Canadian experience in context, Canada’s performance in health was compared briefly to that of other industrialized countries. A rapid review of high performing health organizations / accountable care organizations was carried out with a view to better understanding the characteristics of high performing health systems that might be of relevance to the study of regionalization across Canada.

Interviews

Senior health leaders from across Canada were identified, representing each province and territory. From these, 32 were selected on the basis of expertise and extensive experience in the subject matter. These included current and former deputy ministers and assistant deputy ministers, current and former CEOs of RHAs, senior academics including a dean, and leaders of key Canadian health organizations.

Thirty out of 32 invitees agreed to participate (a response rate of 94%) and were subsequently interviewed. Every province and two out of the three territories were represented (See Annex 2. Name of Study Participants). Anonymity of responses had been guaranteed in the invitation letter and interviews were not recorded, enabling respondents to be more at ease and candid in the interview. They were provided with a set of open-ended questions prior to the interview and the interview proceeded according to these questions (See Annex 1. Open-ended questions for interview of study participants). Detailed interview notes were typed during the interviews and finalized soon thereafter; more than one individual took notes during most interviews.

The findings of both the scoping review and the interviews were reviewed and discussed periodically by the research team to distill the major findings and develop a vision and a practical way forward for potential implementation by provinces and territories.
RESULTS

What were the objectives and expectations of regionalization across Canada?

Better health

An expectation of regionalization in Canada that most interview respondents identified was an increased focus on population health and a shift of the system upstream to act on the findings of population health research and on the social determinants of health. This was expected to manifest as a shift in focus from acute and institutional care to primary care, community-based care and population health approaches, leading to better health outcomes. The Public Health Agency of Canada defines the population health approach as “a unifying force for the entire spectrum of health system interventions — from prevention and promotion to health protection, diagnosis, treatment and care — and integrates and balances action between them” (Public Health Agency of Canada, 2012). For the purposes of this report, we will refer to population health approaches as those approaches which include (1) population-based healthcare service delivery, (2) public health, or (3) intersectoral action for health. In Quebec, an additional goal of regionalization was to foster such intersectoral action for health, which, by definition, encompasses actions taken by sectors other than that of health (e.g. education, transportation, finance, etc.), which also contribute to positive health outcomes (Québec, Gouvernement du, 1988).

This expectation of better health was also outlined in the literature, in which population health and preventive care were frequently identified as elements that would be improved by regionalization. The 2008 Manitoba Regional Health Authority External Review Committee (MRHAERC), for example, noted an intent to improve the focus on wellness and prevention activities (Manitoba Regional Health Authority External Review Committee, 2008). In British Columbia, regionalization was expected to “broaden the notion of health” (Weaver, 2006). And, in Quebec, the creation of local health networks was intended to build specialized service programs to address specific population health needs such as care for the elderly or cancer patients (Demers & Pelchat, 2013).

Ontario, however, was identified by experts as an exception, where Local Health Integration Networks (LHINs) were not expected to take on such an approach. One respondent noted that the goals of the LHINs are driven by the indicators they measure, which, for the most part, do not include those of population health.

Health outcomes were expected to improve, as some respondents commented, not only as a result of the population health focus that would accompany regionalization, but also as a long-term outcome of the better care that was intended to occur. As one respondent noted, however, the healthcare system has a limited impact on health outcomes. Various other determinants of health lie outside the system and play large roles in determining health outcomes. The value of a population health approach therefore lies in its ability to target some of those determinants.

Better care

Also among the expectations of regionalization that most experts identified was the consolidation of previously fragmented health services across the continuum and of funding envelopes and management processes. This was intended to enhance the coordination of care and establish a more integrated system of care. Such a cohesive system would subsequently be expected to improve both the experience and the outcomes of care, as well as enhance the ability to roll out healthcare initiatives with relative ease.
Regionalization was additionally expected, as some respondents noted, to bring the planning, decision-making and management of healthcare services closer to the point of service delivery, and therefore closer to patients and communities. Such localized models of care, as well as the shift to community-based care, would ensure that programs, services and allocation decisions are more locally appropriate, evidence-based and relevant to population needs.

Also relevant to better care was the objective of creating a platform for the continuous improvement of care in British Columbia and a focus on improving the cultural safety of services provided to First Nations through the creation of the province’s First Nations Health Authority, as well as providing care within First Nations’ holistic definition of health and wellness. Quality improvement was similarly identified by respondents from Quebec, Ontario and Saskatchewan as an expectation, albeit a minor one.

The literature similarly identifies better care as a potential outcome of regionalization, including the improved coordination and integration of services, increased planning around population health needs, and an overall improved quality of care (Manitoba Regional Health Authority External Review Committee, 2008; Collier, 2010; Born K, Sullivan T, & Bear R, 2013). Specific examples include Quebec, where the anticipated effects of the changes mandated by Bill 10 (as of April 1, 2015) include better integration and accessibility of healthcare services through a two-tiered management structure and a focus on the continuity and proximity of services (Quebec National Assembly, 2015). Conversely, the move to a single health authority in Alberta was also hailed as a way to increase access to services, reduce regional inequalities, and form a seamless provincial health system (Collier, 2010; Born K, Sullivan T, & Bear R, 2013; Donaldson C, 2010).

**Better value**

The rationalization of services with the aim of reducing duplication, cutting costs, and improving the efficiency of the healthcare system was identified by most respondents as a primary objective of regionalization, be it a hidden one or one that was made explicit during those times of fiscal restraint in which regionalization was rolled out. This is in line with findings from our literature review, which identifies economies of scale, the elimination of duplication, improved coordination of services, and better planning as key practices brought about by regionalization to realize cost-savings in financially constrained times (Manitoba Regional Health Authority External Review Committee, 2008; Born K, Sullivan T, & Bear R, 2013; Baker G, 2008; Church & Smith, 2007).

Better value was additionally expected to be achieved, as many experts pointed out, through the enhanced ability of RHAs to align resource allocation with the needs of local populations. This was particularly expected to be achieved by reallocating resources from the acute care sector to community-based care and population health approaches. Such reallocation would be enhanced by regionalization’s ability to bring decision-making and the planning and management of healthcare services closer to the point of delivery, as well as by the devolution of authority from provincial ministries of health to RHAs. In the case of the First Nations Health Authority in British Columbia, respondents additionally noted the improved ability to implement new models of care that are driven by the First Nations, allowing them to take control of their health and derive increased value from the provincial healthcare system.

**Engaging patients, citizens and communities**

Few interview respondents identified the enhanced engagement of patients, citizens or communities with the healthcare system as an expectation of regionalization. In Quebec, such enhanced engagement and participation were expected to occur by transferring decision-making and
responsibilities to the regional level. Other respondents mentioned this expectation in reference to the LHINs in Ontario, suggesting they could increase of community involvement and citizen engagement in the healthcare system.

This expectation was more prominent in the literature, and included increased public participation and ownership (Manitoba Regional Health Authority External Review Committee, 2008); greater responsiveness to local priorities (Born K, Sullivan T, & Bear R, 2013); shifting power closer to citizens and their communities (Church & Smith, 2007); moving care ‘closer to home’ and enhancing public participation and responsibility in decision-making processes (Weaver, 2006); and bringing leadership closer to populations, leading to better health system responsiveness (Donaldson C, 2010). These concepts are founded on the idea that there are more opportunities to engage citizens and communities within a decentralized system.

Engaging healthcare executives, managers and providers

The Canadian Foundation for Healthcare Improvement (CFHI) has identified six Action Levers to accelerate healthcare improvement (Figure 2). One of these is “engaging healthcare executives, managers and providers in creating an improvement culture” (Canadian Foundation for Healthcare Improvement, 2015). Several respondents noted that regionalization could foster such engagement as managers and providers became responsible for a defined population and set of communities. The literature is sparse on this issue (Weaver, 2006).

Figure 2. CFHI’s Six Levers to Help Organizations Accelerate Healthcare Improvement
**Strengthening information systems**

Strengthening information systems is critical to evidence-informed decision making, another CFHI Action Lever. While many respondents identified strong information systems as key to high performing health systems, very few mentioned this as a specific expectation of regionalization.

**Effective governance**

Regionalization has been seen as a means to address shortcomings through better management (Weaver, 2006; Church & Smith, 2007), and has carried the promise of improved governance and better accountability (Manitoba Regional Health Authority External Review Committee, 2008). Several participants identified the devolution of responsibilities for healthcare planning and the decentralization of authority from provincial governments to RHAs as an objective of regionalization. This is also reflected in the remarks previously described on bringing the planning, decision-making and the management of healthcare closer to the point of service delivery, patients and communities. Several experts commented that regionalization's objective was to depoliticize healthcare decision-making, and that by pushing decision-making to lower levels, provincial governments hoped to avoid some of the politics related to healthcare delivery. This was also described in the literature, where regionalization in Alberta was seen as a way to get rid of 'local health empires' (Born K, Sullivan T, & Bear R, 2013).

On the flipside, the centralization of governance and authority from the local to the regional level was also identified as an objective of regionalization. One exception to this would be Ontario, where hospital and other institutional boards have been retained and three levels of governance exist: the local (institutional boards), the quasi-regional (LHINs) and the provincial (Ministry of Health and Long-Term Care – MOHLTC). This is in contrast to the two levels of governance that exist in other provinces: the regional (RHAs) and the provincial (ministries of health).

Whichever way it is described, the expectation was the same and can be expressed as enhanced governance and leadership of healthcare at the regional level.

**Creating supportive policies and incentives, fostering innovation**

In a 2010 opinion piece about health policies in Alberta, Donaldson identified centralization as a means to create a high quality, innovative system (Donaldson C, 2010). Innovation was not identified by interview respondents as an expectation of regionalization; as we will see in the following section, innovation was however a clear result of regionalization.

**What were the Outcomes/Realizations of Regionalization across Canada?**

**Better Health**

The improvement of health outcomes in this discussion can be perceived as resulting from the enhanced delivery of evidence-based services and programs, along with strengthened public health, population health approaches and intersectoral action for health. Although most respondents felt that the health of Canadians has improved over the past decade, opinions varied on whether these improvements can be attributed to regionalization. This is due to the dearth of rigorous evaluations and the confounding variables at play; and is confirmed by the paucity of scientific studies the literature review revealed concerning associations between regionalization and improved health in Canada. Whatever literature exists consists of mere observations or author opinions that have not isolated regionalization as a causal factor for any of the changes in health that have been observed. There is therefore a limit, despite the opinions of interview respondents, to the degree to which any observed changes can be truly attributed to regionalization.
That being said, there was general consensus among interview respondents that regionalization has increased the focus on public and population health and on the needs of local populations, as well as enhanced the ability to discuss how resources can best be allocated to meet those needs. Such sensitivity to local needs might not have occurred in a centralized system, as one respondent from Quebec put it, where every region is described as having its own “mini” health system. The population health division of Alberta Health Services (AHS) was cited as bringing greater attention to, and assuming a larger role in addressing population health. Other provinces that have achieved this shift include New Brunswick and Newfoundland & Labrador, where community needs assessments are conducted with input from community and public health stakeholders, and Saskatchewan, where population health approaches have been integrated with nearly every portfolio and intervention in the regions. An increased focus on population health has also occurred in Manitoba, where a significant amount of resources has been reallocated from hospitals to the community.

Opinions in the literature lend further support to this impact of regionalization. In 2008, Lewis heralded the population health agenda as one of the “unsung triumphs” of the regionalized structure in Alberta, and referred specifically to its success in educating boards about non-medical health determinants and on the importance of addressing the upstream causes of poor health (Lewis, De-Regionalizing Alberta: The Road to Reform of Collateral Political Damage? And then there was one, 2008).

An increased capacity to work with public health was also cited as a positive impact, with Saskatoon as an example in which public health has been granted a voice in decision-making that, according to the respondent, would not have occurred in the previous era of hospital boards. Quebec constitutes another example in which the integration of public health with regional authorities was attributed to regionalization. Integration was limited in Ontario, however, where public health has remained the responsibility of municipalities, the boundaries of which do not align with those of the LHINs. Although this strong link between public health and municipalities has had a number of benefits, including the promotion of intersectoral action, several respondents expressed the need for tighter integration between LHINs and public health in Ontario. The potential for such integration to improve health outcomes can be observed in the gains that have been achieved, as one respondent noted, from the integration of public, population and Aboriginal health within AHS in Alberta.

On the other hand, there are those who view the integration of public health within RHAs as having negatively impacted its effectiveness for certain functions. This has been crystallized in British Columbia, where the de-centralization of public health functions to RHAs was described as having negatively impacted the effectiveness of certain aspects of health promotion in the province. This emphasizes the importance of choosing the appropriate population size for different public health functions, which some respondents pointed out as necessary for optimizing program effectiveness and efficiency (regional vs. provincial).

Another aspect, according to several interviewees, that was enhanced by regionalization is intersectoral action for health. It was particularly enabled, as one expert commented, in provinces in which the boundaries of RHAs aligned with those of other services and institutions. Examples include British Columbia, Saskatchewan, Quebec and Newfoundland & Labrador, where regionalization has facilitated partnerships between the health sector and other sectors such as the police and community services to target issues of concern, including drug abuse, homelessness and mental illness. Intersectoral action between the health and education sectors has also led to the implementation of healthy public policies in schools in Newfoundland & Labrador to reduce childhood obesity.
In terms of health outcomes, although interview respondents were generally cautious about attributing any changes to regionalization, the literature provides some indication of their improvement. Such improvements, however, appear to have been measured only for certain procedures or populations, and the literature citing them suffers from the limitations previously mentioned. As one example, in the former Calgary Health Region, reductions in lengths of stay and in-patient and 30-day mortality rates for acute myocardial infarction were attributed to the health region’s efforts to redesign care processes (Baker G, 2008). However, the provincial, centralized approach has similarly been documented to have improved patient survival rates through its implementation of the Provincial Stroke Strategy (Mazurkewi, 2012). This suggests that further studies are required to assess any impacts regionalization may have had on health outcomes, as opposed to more centralized approaches.

**Better Care**

The consolidation of services and the reduction in the fragmentation of care, accompanied by both the vertical and horizontal integration of services across the continuum was mentioned by most study participants as a positive impact of regionalization. Examples included Alberta, British Columbia, Quebec, and Newfoundland & Labrador, as well as Ontario, where LHINs were described as having taken integration a step further by additionally considering the co-location of services. The literature also emphasizes this impact. In their pan-Canadian review, for instance, the MRHAERC found that despite varied levels of success across the country, there has overall been a reduced fragmentation of systems, less duplication of hospital services, and an increase in partnerships throughout the healthcare system (Manitoba Regional Health Authority External Review Committee, 2008). Specific examples include Alberta, where the government attributed improved integration and continuity of care and reduced inter-facility competition in 2006 to the regionalized structure (Government of Alberta, 2006).

As one expert explained, such an integrated system allows for the mobilization of the whole system during a crisis, leading to better responses and outcomes. Others also maintained that integration has allowed not only for improved access to various services (mental health, long term and home care in Manitoba and PEI), the coordination of care (Saskatchewan, Quebec, Newfoundland & Labrador) and the integration of social services with health (Quebec, following the recommendations of the Rochon Commission), but also the availability of a variety of means to deal with problems, thus leading to more effective solutions (Québec, Gouvernement du, 1988). In Saskatoon for example, partnerships with local ambulance providers and homeless shelters to improve access of homeless populations to mental health and addiction services were said to have been made possible by the integration of services that accompanied regionalization. The literature likewise attributes improvements in access to and the coordination of healthcare services in Manitoba to regionalization, as well as within health regions in Alberta such as the Calgary Health Region (Manitoba Regional Health Authority External Review Committee, 2008; Baker G, 2008).

However, integration cannot be considered complete in any of Canada’s provinces. Many participants lamented the limited nature of population health action and nearly every participant identified the exclusion of physicians from regionalized structures, and of physician contracting and remuneration – especially in primary care as key challenges. The other major exclusion is that of pharmaceuticals from regionalized budgets. One respondent made the argument that in such a case, integration fails to reflect the production process (i.e. the provision of healthcare) since it excludes important parts of the process (i.e. physicians). Cost savings cannot therefore be expected unless integration reflects the production process as per the Theory of the Firm (Coase, 1937).
The unexpected amount of time, effort and change management required to implement clinical integration in New Brunswick was described as a further challenge. Another recognized weakness was the danger that regionalization may pose to integration at the provincial level. It was explained how, in the absence of a culture of knowledge-sharing and non-competitiveness, regions can constitute variable health systems within the province and contribute to the abolition of integration and information-sharing at the provincial level. Similarly, it was described how in a few instances regions went beyond simply adapting services to local needs, but rather contradicted governmental policies.

These incomplete features of regionalization are also suggested in the literature. In a report in 2006, the Government of Alberta found that the regionalized structure had failed to provide strong incentives for health regions to collaborate and share information, resources and best practices. Rather, it had led to competition and rivalry between regions for funding (Born K, Sullivan T, & Bear R, 2013; Government of Alberta, 2006). The Auditor General of Alberta similarly reported in 2006 the lack of province-wide coordination between regions, despite within-region successes. As such, the centralization of the healthcare system was identified as a possible way to address this fragmentation, and does in fact seem to have succeeded in improving certain care processes, such as through the development of its provincial stroke strategy (Mazurkewi, 2012; Auditor General of Alberta, 2008). Conversely, other care processes, such as wait times for hip replacement and coronary artery bypass graft rates, do not seem to have been improved by Alberta's centralized approach to healthcare (Donaldson C, 2010).

Another impact of regionalization identified by respondents was an increase in the capacity to reallocate resources across services, as well as to adjust service delivery plans to meet regional needs more adequately. Examples were cited in British Columbia, Manitoba, Newfoundland & Labrador and Quebec of budgets being shifted from acute care to community services, ambulatory care, home care and chronic care services. As one respondent described, this at least theoretically allows for the provision of more appropriate care at a more appropriate time and in a more appropriate place. Examples are also evident in the literature, which points to the achievement of appropriate balances in British Columbia between local surgery services for low risk patients on the one hand, and more advanced procedures and services in regional centres on the other (Iglesias & Caron, 2007). Marchildon states, however, that although regionalization has shifted funding from an institution and service-specific format to one more comprehensively allocated to RHAs, there exist no specific entries in the literature that demonstrate an improved quality of care linked to regionalization (Marchildon, 2013). Additionally, respondents described the ability to reallocate resources as often being hindered by RHAs' lack of sufficient authority to make such decisions due to provincial-level interference. The capacity to reallocate resources was thus observed by some to not have been fully achieved with regionalization. This is discussed further in the next section.

Regionalization was also noted to have enhanced the provision of relevant care by bringing planning, decision-making, and management closer to the point of delivery, aligning care with the local needs of populations. There is debate in the literature as to whether this is in fact desirable. In 2011, for example, Duckett pointed to how local decision-making in Alberta's regionalized structure led to inter-regional inequalities in the availability and delivery of healthcare services, cataract surgeries being one example (Duckett, 2011). However, centralization of Alberta's system does not seem to have ironed out these inconsistencies in the delivery of services, as a former Premier was said to have remarked (Gorman, 2015). Others have also countered that service provision should be tailored to the population served.
The majority of respondents identified a boost in evidence-based decision-making as another impact of regionalization. Decisions were seen to be not only better, one participant claimed, but also easier to make in the context of RHAs. This may be, as another put it, because regions possess the capacity and leadership to marshal the information and analysis required to enhance decision-making and to align it with regional needs. This capacity is currently being enhanced in Nova Scotia, where efforts are ongoing to standardize information systems to make comparable information available for use in evidence-based decision-making.

A few respondents, however, expressed uncertainty concerning the extent to which regionalization has promoted evidence-based decision-making. In Quebec, variability was noted across regions in the ability to base decisions on evidence and was largely attributed to the variable strengths of the regional teams leading such initiatives. Also in Saskatchewan, the ability to make evidence-based decisions was noted to yet be fully realized. This may be because, as one expert explained, evidence-based decision-making is a challenging endeavor that can’t just be “switched on”. Rather, it is a process that requires commitment, resources, and skills that LHINs in Ontario for example, do not yet fully possess.

Another impact of regionalization within the context of better care relates to building organizational capacity and networks. Regionalization, as described by one expert, provides a stronger foundation to strengthen organizational capacity and networks and to act as one. Larger networks of interactions were perceived to result from the engagement and deliberation required to make allocative decisions in a regionalized structure. The increase in organizational capacity and networks was additionally attributed to scale, particularly in rural areas. Also, among the identified benefits of such networks of practice was the enhanced ability in New Brunswick to identify and standardize best practices across the province.

A small number of respondents remained skeptical about regionalization’s ability to enhance organizational capacity and networks. One respondent claimed that regionalization is not necessary for the formation of networks, especially at the clinical level. Another explained how regionalization should have strengthened organizational capacity, but how evidence of such an effect is lacking. Capacity in Ontario was said to have been diminished with the closing of district health councils and the centralization of their analytic capacity to the provincial government.

The majority of respondents, however, held the view that regionalization has enhanced organizational capacity and networks.

Better care involves indicators related to quality improvement. Some respondents pointed out the difficulty of attributing improvements in the quality and accessibility of care to regionalization since efforts in these areas have been mainly driven by provincial ministries of health. Several pointed out the achievements Ontario has accomplished in primary care reform, wait times, and the reallocation of resources despite the absence of a fully regionalized structure. However, the improved standard of care in Manitoba was attributed to the expertise that has accompanied the scale and volume resulting from regionalization. This is supported by the literature, which points to best practices that have been implemented across Manitoba’s regions as a result of regionalization (Manitoba Regional Health Authority External Review Committee, 2008). Regionalization was likewise cited by respondents to have improved quality and patient safety in Quebec and Yukon, and contributed to the development of process improvement approaches such as the Lean initiative in Saskatchewan and New Brunswick (Institute for Healthcare Improvement (IHI), 2005).
The one jurisdiction that reported negative impacts on all the aforementioned fronts was the Northwest Territories. “Pockets of excellence” were acknowledged to have arisen from locally responsive efforts, however, it was described as a system that delivers fragmented services via eight RHAs and one territorial health authority to a population of only 42,000. This has led to situations in which patients “fall through the cracks”, as well as an inability to consistently gather the evidence that should inform decision-making, competition between RHAs for resources, a lack of clinical standards, and consequent inequities in service. In response to this situation, the NWT adopted Bill 44, An Act to Amend the Hospital Insurance and Health and Social Services Administration Act, in June 2015 to establish an integrated territorial authority (Northwest Territories, Government of, 2015).

These outcomes suggest that the number of RHAs set up to serve a minimum population size is an important factor and can play a significant role in how effective regionalization is in achieving its objectives, even in very large geographic areas. It may also explain the recent trends across Canadian provinces in reducing the number of regions.

**Better Value**

Success in meeting the objective of fiscal restraint was noted by several respondents, but countered by others. Cost savings were cited in British Columbia, Manitoba and New Brunswick, part of which were attributed to regionalization. The integration of acute care and long-term care facilities in Saskatchewan and Quebec was said to have resulted in economies of scale. The literature, however, points to the inability to fully achieve such economies of scale in smaller provinces and regions due to population size. Regionalization to nine district health authorities in Nova Scotia in 2001 constitutes one example in which economies of scale were not realized (Black & Fierlbeck, 2006). This is likely due in part to the fact that the average population size of these district health authorities was only around 100,000, preventing economies of scale.

A few respondents also claimed that there were in fact no real differences in costs. Cost savings achieved in Alberta have been attributed to reduced administrative costs (Mazurkewi, 2012; Duckett, 2011). Interview respondents, however, claimed that savings began prior to regionalization, suggesting that any that continued during regionalization may not have been attributable to the structural change. This is supported by the literature where there is a lack of data demonstrating causality between the creation of regionalized structures and decreased costs. Respondents also noted that in both Nova Scotia and Saskatchewan, there a lack of evidence that savings occurred, but also significant initial costs to restructuring the system, including investments in Nova Scotia to standardize information systems across the province. Donaldson cites such unforeseen costs in Alberta, which counterbalance any realizations of cost savings (Donaldson C, 2010). These include the costs incurred from moving patients’ greater distances, which decreases the economic benefits of centralized care, as well as increased out of pocket expenditures by patients and their families, as was cited to have occurred in British Columbia (Iglesias & Caron, 2007; Gerst, 2011). Costs related to managing the recent reform in Quebec were cited by interview participants as a source of concern. The Northwest Territories also suffered financially due to their regionalized structure, which has led to waste, inefficiencies, the duplication of non-clinical functions between the 8 very small RHAs (<10,000 population on average), and an accumulated structural deficit in the system.

Another aspect of better value comprises an improved efficiency of the system and a rationalization of services, which was to have been successfully achieved by LHINs in Ontario, where duplications that had previously existed were reduced. Rationalization of emergency departments in PEI was attributed to regionalization, as was the improved management of highly utilized services in Quebec, including those of emergency departments.
Better value also consists of an enhanced capacity, albeit modestly, to reallocate resources within regions. Some experts identified two barriers that prevent regions from fully achieving this capacity: the exclusion of physician contracting and remuneration from regional structures, and interference from provincial ministries. The limited authority of RHAs to make such decisions was perceived as another important barrier, as was the aging population and subsequent pressures on the acute care system. Regionalization should theoretically allow for funding on a population basis. In practice, however, it was noted that the majority of budgets appear to be the same as they were prior to regionalization. This was reinforced by comments on how attempts to reallocate funds are challenging and distributions therefore tend to remain the same as they were, except for rare cases in which regional boards are exceptionally effective or allocations are driven by skillful administrators. It was noted that changes in allocation models, such as shifts to population-based funding models, have largely been a provincial, rather than a regional effort and cannot be attributed to regionalization.

There have nonetheless been instances of success in which regionalization was seen to have positively impacted resource allocation, shifting it upstream to a focus on population health needs, and from the acute care to the community-based sector (e.g. British Columbia, Manitoba, Quebec, Newfoundland & Labrador). The literature suggests that such shifts to community-based care can favorably impact rates of institutionalization and cost (Johri, Beland, & Bergman, 2003). The recently re-centralized structure in one Canadian province also possesses the potential for enhanced resource allocation, as one expert remarked, but is dependent on an improved vision and on congruity between the regional authority and the provincial government. Role clarity is necessary to enhance the ability to allocate resources in a more efficient manner.

Engaging patients, citizens and communities

Regionalization was identified by several experts as having led to a loss of citizen engagement in governance and of a local sense of ownership of the healthcare system. These were attributed to the centralization of authority from the local to the regional level and the dissolution of local institutional boards. This is supported by the literature, which highlights the fears expressed by rural areas of a loss of voice in decision-making as it is centralized to the regional level, as well as a loss of accountability to local populations and a decline in the empowerment of citizens through local community governance (Collier, 2010; Denhaan, 2008; Ktpatzer consulting, 2006).

Also as indicated by the literature, representativeness, and especially of marginalized populations, is an important element to be considered within the context of citizen engagement (Lewis, De-Regionalizing Alberta: The Road to Reform of Collateral Political Damage? And then there was one, 2008; Simpson, 2011). Authors point to the lack of legislation or policies that ensure the representation of Aboriginal communities in regional health boards or in provincial health systems (Lavoie, Boulton, & Gervais, 2012). There are notable exceptions, however, including Inuit and Cree communities in Northern Quebec that each constitute their own health region and possess strong Aboriginal representation on their regional health boards. Similarly, the creation of the First Nations Health Authority in British Columbia has ensured stronger First Nations representation in the governance of the healthcare system.

It was also maintained by one interview participant that regionalization alone is not enough to ensure citizen engagement in the system. The increase in patient participation that has occurred in Saskatchewan through patient organizations, councils and patient/family advisors, for instance, was perceived as independent from regionalization and not attributable to it. Furthermore, the literature questions the effectiveness and ultimate influence of citizen engagement, even when achieved (Ktpatzer consulting, 2006; Abelson & Eyles, 2002). In a 2009 report by the Change Foundation, 44.8%
of participants indicated that it was either ‘very difficult’ or ‘difficult’ for their LHIN to apply the results from community engagement in setting plans and priorities (The Change Foundation, 2009).

Despite these challenges, interview respondents conceded that regionalization has been successful in bringing decision-making closer to the point of care, and closer to patients, citizens and communities. In this sense, it has been successful in enabling care that is more patient-centered and responsive and that is more suited to the local needs of citizens and communities.

Others held that regionalization creates a platform for public involvement in the system, the capacity at the regional level to engage citizens and patients in planning processes, and increased discussion with elected municipal officials on matters related to health. The literature supports this notion of increased public participation, and examples are cited where locally elected boards were better able to take on advocacy roles for their communities, while linking to larger organizations and networks at the provincial and national levels (Ktpatzer consulting, 2006). Communication between the system and the public was also noted by respondents to have improved in Manitoba, allowing for a more transparent system. Similarly, the mandates of LHINs in Ontario and of RHAs in New Brunswick to engage citizens have been responsible for the involvement of communities in these provinces through various committees, focus groups and public consultations. Communication with community representatives was said to have been set up in Newfoundland & Labrador, leading to enhanced citizen engagement. An increase in the patient and public voice at the local and regional levels was also noted in Quebec, the Yukon and the Northwest Territories. Citizen engagement in Quebec, although described as minimal at times, was said to have been revived by the population health approach and to have contributed to an intersectoral approach to health in the province.

Engaging executives, managers and providers

Study participants indicated that healthcare executives have been increasingly involved in the planning process at the regional level. In New Brunswick, for example, the engagement of managers in the healthcare system was achieved by establishing a leadership advisory council comprised of both regional directors and medical leaders. Enhanced engagement through the formation of a leadership development program and a provincial medical advisory board in PEI was attributed to regionalization. Similar successes were cited in Yukon and Newfoundland & Labrador, as well as in Saskatchewan, where managers were engaged through quality councils, quality improvements in healthcare organizations, and the adoption of the Lean initiative (Institute for Healthcare Improvement (IHI), 2005). The literature also notes success in the Montérégie region of Quebec, where staff and clinical and administrative leadership have been engaged in a cancer control program (Touati, et al., 2007).

In Ontario, the ability of LHINs to engage healthcare executives and providers was attributed not to the power held by those who lead the networks, but rather to their leadership capabilities. Some LHINs have been more successful at this engagement than others.

Failure to engage was also cited in Alberta, where nurses were described as disengaged from the system, and where the 1995 and 2008 structural changes were depicted as disturbances that damaged and alienated a whole generation of healthcare professionals. This finding is echoed in the literature as the toll restructuring takes on leadership and the anxiety it causes among staff (Born K, Sullivan T, & Bear R, 2013; Lewis, De-Regionalizing Alberta: The Road to Reform of Collateral Political Damage? And then there was one, 2008). However, it was also noted in one study that middle management played an important role, as did an organization-wide approach to learning through experimentation in implementing changes in healthcare delivery during regionalization (Golden-Biddle, 2006).
Engaging physicians

Regionalization was reported by both interview respondents and the literature to have neglected to integrate physicians, physician budgets and modes of remuneration into RHAs in every jurisdiction that has adopted a regionalized model (Weaver, 2006; Collier, 2010; Kirby, 2002). This, along with the dissolution of institutional boards that accompanied regionalization, has led to a disengagement of physicians from regionalized structures. This is not surprising, given that the engagement of physicians was never stated as a goal of regionalization and authority over physician remuneration was not granted to health regions. In many examples, it seems as though health regions have been placed in the untenable position between a ‘rock’ (provincial governments which fail to devolve authority) and a ‘hard place’ (strong physician advocacy groups opposed to change that would affect their remuneration or professional autonomy) (Minister’s Task Force on Regionalized Health Care in Nova Scotia, 1999; Boychuk, 2009; BCMA Council on Health Economics and Policy, 2002).

As one respondent put it, given that physicians control over three quarters of health expenditures, their disengagement from the system constitutes one of the largest limitations of regionalization in Canada and contributes to a lack of physician accountability at the local and regional levels. The literature supports this, showing that physician remuneration is one of the major health expenditures (up to 15% of overall spending on health) and lies outside the control of health regions (Collier, 2010; Born K, Sullivan T, & Bear R, 2013; Canadian Institute for Health Information, 2013). Respondents described how the lack of physician integration has impeded the ability of RHAs to exert any form of oversight over the nature and consequences of medical practice and to participate in primary care reform efforts. Health ministries have largely retained the authority to negotiate physician payment through provincial contracts with unions (Kirby, 2002; Verma, Petersen, Samis, Akunov, & Graham, 2014). This lack of devolved authority has been a longstanding criticism of how regionalization has been implemented in Canada (Verma, Petersen, Samis, Akunov, & Graham, 2014; Canadian Medical Association, 2010).

Interview respondents noted that physicians have been left out of not only RHAs, but also the discussion around how healthcare systems should be regionalized. This was attributed to the politicization that currently characterizes such discussions. In Alberta, for instance, the introduction of family care clinics was cited to have occurred in the absence of any dialogue with physicians in the province. This was also seen in the literature. Across Canada, the Canadian Medical Association found that regionalization led to change in the leadership roles played by physicians, as well as their opportunities to provide input for system change (Canadian Medical Association, 2010). Several reports describe how regionalization has eliminated or reduced several of the forums for physician input into governance and decision-making within health systems. In ‘virtually all jurisdictions’, physicians no longer have a position on governing boards (Church & Smith, 2007; Canadian Medical Association, 2010; Society of Rural Physicians of Canada, 2004; CBC News, 2012; New Brunswick Medical Society, 2013). As a result, the literature reports significant disengagement, dissatisfaction and feelings of alienation among physicians (Born K, Sullivan T, & Bear R, 2013; Baker G, 2008; BCMA Council on Health Economics and Policy, 2002; CBC News, 2012; Cowell, McBrien-Morrison, & Flemons, 2012).

That is not to say, however, that efforts have not been made to boost the engagement of physician leaders. Interviewees pointed to examples such as New Brunswick, where regional and local medical advisory committees have been established, and where physicians have been included in discussions with other leaders and involved in the quality improvement program. Their involvement in a leadership development program and the provincial medical advisory board was described in PEI, as was regionalization’s strengthening of physician engagement in Newfoundland & Labrador and
through regional departments of general medicine (DRMGs) in Quebec. Other examples include British Columbia and Saskatchewan, both of which have formally adopted the concept of physician leadership and developed co-leadership structures in which clinical programs are increasingly led by physician and non-physician co-leads. Physicians have similarly been increasingly involved in the planning processes of LHINs in Ontario, where the need for clinical leads for primary, emergency and critical care within LHINs has been realized. Despite provincial control over the fee-for-service (FFS) remuneration of physicians in Manitoba, RHAs now manage the salaries of physicians in some hospitals. This represents one step closer to their integration within the health regions.

Examples are also seen in the literature. In 2011, the Regina Qu’Appelle Health Region (RQHR) of Saskatchewan identified involvement in decision-making and trust and respect between physicians and administrators as areas for improvement. In order to address this situation, the health region launched an Enhancing Physician Engagement Project based on the foundations of acting together and deciding together (Grimes & Swettenham, 2012). Another, older example lies in Alberta, which supported physician-generated projects that demonstrated innovative ways to improve service delivery through a three-year $10 million fund. Other initiatives aimed at improving physician engagement included a medical task force to increase communication between physicians and regional health executives; solicitation of physician input in regional initiatives; and financial subsidies and dedicated time for quality improvement training and project participation (Baker G, 2008).

**Strengthened information systems**

As one respondent put it, the creation of larger and more complex organizations creates both the need and the capacity to develop stronger information systems. These allow for enhanced communication and information-sharing, better decision-making and resource allocation, improved management and evaluation of the system, and increased transparency. The capacity for strengthened information systems, however, has not been realized in any province. Respondents decried the weakness of information systems, the lack of their standardization across regions, their weak linkage to electronic medical records, and the lack of systematic data collection and evaluation of regionalized healthcare structures using such systems. This is supported by views in the literature, which underline the lack of proper tools to measure performance across Canadian provinces, as well as a lack of funding for information and communication technologies, such as in Manitoba (Manitoba Regional Health Authority External Review Committee, 2008; Gerst, 2011). According to interviewees, this failure to evaluate the system hinders the development of an evidence base related to regionalized structures, contributing to the previously described inability to attribute with complete certainty any impacts on health, care or value to regionalization.

Despite the overall weakness of information systems, a few local, isolated efforts were reported by interview respondents. In Vancouver, a mental health information system has been developed that allows the system to track individuals with serious mental health issues. Another example lies in Nova Scotia, where efforts are being made to standardize previously variable data formats and consolidate information systems. The health information system in PEI was likewise reported to have been expanded with regionalization, leading to an enhanced analytic and evaluative capacity.

The literature reveals a similar utilization of information systems in Alberta that can be attributed to regionalization, including the implementation of the Patient Care Information System (PCIS) and the Community Care Information System (CCIS), the development of telehealth services, and the use of regional hospital and clinic computerized systems to track patients’ mental health information (Baker G, 2008; Mazurkewi, 2012; Auditor General of Alberta, 2008; Duckett, 2011). However, one of the limitations identified in the province had been the difficulty of sharing this information between regions (Duckett, 2011).
Effective governance

With regionalization, there was a promise of enhanced governance and leadership and better management of the healthcare system. Elements of this have been addressed in previous sections – accountability and transparency, stakeholder negotiations, information systems for enhanced health program decision-making and resource allocation. This section focuses on changes to management and governance processes at the regional level, as well as relationship between provincial governments and the regions.

Interview respondents acknowledged regionalization’s objective of centralizing governance and consolidating authority as having been achieved within each region. Local institutional boards in most provinces were dissolved and their mandates consolidated into RHAs. The only exception remains Ontario, where institutional boards remain and receive their budgets directly from the government. Hence, LHINS lack authority over these institutions. In other jurisdictions, decisions to rationalize services in the acute care sector and reallocate resources became easier to make in the context of RHAs, albeit not always to the fullest extent possible.

Additionally, the ability of RHAs to make decisions (such as those related to resource reallocation) has remained incomplete. This is because regionalization’s complementary objective to devolve authority from provincial ministries of health to RHAs was unanimously described by interview respondents as having only been partially met. Failure to do so was attributed to insufficient devolution in legislation (governance and management), micromanagement by provincial ministries that often fail to eliminate functions that had been transferred to RHAs, and frequent political interference. Such intrusions have prevented RHAs from fully exercising the devolved authority they were meant to possess. The resulting tensions between provincial governments and RHAs were perceived by one respondent as having led to the reduction of the number of RHAs in Alberta, PEI and Nova Scotia. Some responses similarly reflected the concern in Quebec for a loss of regional governance with the implementation of Bill 10.

These viewpoints are supported by the literature, throughout which there is discussion of the varying levels of autonomy and power allocated to health regions. Of the noted barriers to effective regionalization are the “lack of devolution of authority to the regions” and “political interference in the management of the region” (Manitoba Regional Health Authority External Review Committee, 2008; Donaldson C, 2010; Born & Sullivan, 2011). Where ‘autonomy’ and ‘power’ are perceived to be insufficient, this is identified as a barrier to effective functioning and governance. In particular, the following themes were identified: discretion over funding and resource allocation; control of physician and healthcare provider remuneration; control and determination of service provision and delivery; and setting targets and performance standards (Manitoba Regional Health Authority External Review Committee, 2008; Lewis, De-Regionalizing Alberta: The Road to Reform of Collateral Political Damage? And then there was one, 2008).

In Ontario, arguments have been made that when created, insufficient authority was devolved to the LHINS, undermining their ability from the outset to meaningfully fulfill their mandate. This includes discretionary power over funding allocation and distribution (Born & Sullivan, 2011; The Change Foundation, 2008). Similar issues are documented in Newfoundland & Labrador and British Columbia (Tomblin & Jackson, 2006; Government of British Columbia, 2007).

The literature identifies some tensions within health regions between accountability to the provinces and accountability to the communities. One article identified the provinces as winning in this tug-of-war, and describes how provincial control has increased over the healthcare system with recent changes in Alberta, New Brunswick and PEI that have restricted RHAs’ scope of action and consolidated the number of health regions (Phillipon & Braithwaite, 2008).
The literature suggests that, at the time of centralization to AHS in Alberta, there were underlying power dynamics between the regions and the provincial government which led to health regions being disbanded for political purposes and related to power issues (Collier, 2010; Donaldson C, 2010; Lewis, De-Regionalizing Alberta: The Road to Reform of Collateral Political Damage? And then there was one, 2008; Picard, 2010).

Role clarity has been identified in the literature and by participants as a challenge to regions’ ability to exercise their governance and leadership. One interviewee noted that this absence of role clarity has also impacted on clear lines of accountability between regions and provinces/territories ministries. One expert noted that such an absence of role clarity is also responsible, for the difficulty provinces have encountered in setting up and sustaining accountability structures. For example, in a pan-Canadian survey conducted in 2001, the need for improved clarification of the role of regional boards was identified, as was a lack of role clarity of RHA governors and their limited authority and control over services (Manitoba Regional Health Authority External Review Committee, 2008; Chessie, 2009).

Effective governance also relates to the size of the health regions – geographic boundaries and population size are both factors which should be considered when establishing governance structures. Interview respondents pointed to the importance of travel times, timely access to care and oversight by management as key factors when considering the optimal size of a region. One recommendation consisted of ensuring that travel time within a region be no more than three to four hours, and that regional population size not exceed 500,000. The ongoing structuring and restructuring of health regions exemplifies the need to find the ‘just right’ balance of factors. In Nova Scotia, the 1999 task force on regionalization found that feedback from their respondents varied on the appropriate size for health regions within the province. Local providers and communities tended to feel that the regions were too big to understand and address their concerns (a commentary on their perceived ability for input into decision-making processes) (Minister’s Task Force on Regionalized Health Care in Nova Scotia, 1999). In 2005, PEI dissolved their regional boards and created one “region” for the province. Prior to this, six governance entities administered healthcare services for a population of only 140,000 (Phillipon & Braithwaite, 2008).

Interview respondents also described the difficulties that have been encountered in the structural and managerial shift from multiple organizations at the local level to their consolidation in a single, regional entity. These difficulties were attributed to an inadequate focus on – and poor execution of – change management, as well as an underestimation of the complexity of the undertaken changes.

Creating supportive policies and incentives; fostering innovation

Opinions varied amongst interviewees on whether regionalization has fostered innovation and supportive policies in health and healthcare. Most maintained that regionalization has enhanced the capacity for innovation. Several examples concerned innovation in the development of programs that are responsive to local needs, such as the establishment of the “health bus” in Saskatoon. According to some respondents, LHINs in Ontario also possess the ability to fund innovative programs which, if successful, have the potential to be implemented on a wider scale. Such innovation is not, however, consistent across LHINs and is largely dependent on the leadership. Innovation in Quebec similarly varies by region, where Montérégie and Saguenay were cited as two of the more innovative regions. Regionalization in the Northwest Territories was also said to have enhanced innovation in remote Aboriginal communities. On the downside, these pockets of excellence in the Northwest Territories were described as having led to inequalities in service delivery, as well as substantial deficits in situations in which RHAs tap into resources required for the provision of basic services to fund these innovative programs instead.
The literature provides examples of successful innovation. These include the Bois-Franc experiment in Quebec ("L’expérience des Bois-Francs"), an innovation related to services offered to the elderly and which involved the collaboration of multidisciplinary health teams to ensure better service integration for the target population (Demers & Pelchat, 2013). Alberta constitutes another example, in which the health system’s regionalized structure, together with regional competitiveness, allowed for improved inter-regional learning, with each region learning from the innovations of the others (Duckett, 2011). Regionalization in Alberta additionally enhanced responsiveness to community needs, continuity of care, public health, alliances with university research units, health information technology adoption and quality improvement (Picard, 2010).

There were also those who maintained that regionalization has aided the implementation of healthy public policies. These include anti-smoking policies in Newfoundland & Labrador and Saskatchewan, as well as environmental policies and intersectoral work with schools to support healthy food choices among children in Saskatchewan. Policies that are supportive of, and incent the creative use of healthcare resources, were similarly attributed to regionalization.

Some of the experts interviewed, however, perceived regionalization as having had limited impact on the capacity for innovation and supportive policies. There was skepticism concerning the compatibility of innovation and regionalization. One respondent described this incompatibility as the decrease in innovation as organizations increase in size. For instance, it remains to be seen in Quebec if the implementation of Bill 10 will reduce the regions’ capabilities for regional governance and for innovation in healthcare. In New Brunswick, barriers to technological innovation in healthcare were ascribed to financial pressures that have focused efforts on cost control rather than the development of innovative programs. Nova Scotia’s cost trends, which have been generating deficits on a routine basis, were also said to have hindered the capacity for innovation. Among the barriers that were cited in the interviews was, the incomplete devolution of authority from provincial ministries of health to RHAs, which hindered the ability of RHAs to fully take control of the decision-making process that enables innovation.
DISCUSSION

Strengths and Limitations of this study

Strengths

This study used a rapid evidence-based approach consisting of a scoping review of over 250 documents and key informant interviews with 30 of 32 senior health leaders from across Canada. This corresponds to a response rate of 94% with representation from every province and two out of the three territories. Due to the assurance of anonymity, respondents were candid in their responses to questions and in trying to consider how regionalization has contributed to advancing the triple aim of better health, better care and better value in Canada.

This report represents the views of very senior leaders in Canadian healthcare, with a strong convergence of opinion among this group of senior leaders across Canadian jurisdictions. This provides the study’s findings and proposed way forward with significant robustness; this is further enhanced by the fact that the evidence in the literature review is consistent with the results of the interviews.

To validate the synthesis of interview findings, a draft of this report was shared with study participants. Feedback was positive (21 of the 26 respondents strongly supported the findings), thus confirming the robustness of our synthesis. Furthermore, all comments from respondents were taken into consideration and the report was modified accordingly, to better ensure the findings accurately reflect the opinions of the individuals interviewed.

Limitations

Several factors made it difficult to tease out cause-and-effect relationships and to separate the contribution of regionalization to overall improvements in health and healthcare. These included the:

- Lack of relevant healthcare performance data disaggregated at the regional level and the weakness of current information systems;
- Absence of formal evaluations of regionalization across Canada and in many cases the lack of meaningful annual reporting on performance;
- Multiple changes in the structure, functions and numbers of regions that have occurred since the beginning of regionalization across the provinces, precluding an observation period sufficient to draw satisfactory conclusions;
- Fact that much of the literature is in the form of expert opinion and lacks quantitative evidence;
- Lack of a true comparison group, although some would argue that Ontario, not having formally regionalized, could act as a comparator; and
- Fact that interview respondents are limited to healthcare system managers and therefore do not necessarily reflect the opinions of other healthcare professionals or patients/citizens.

The results of this study should therefore be interpreted in light of the above strengths and limitations.

Regionalization in context

Life expectancy at birth has improved in Canada from 77 years for men and 82 years for women for the period 2000 – 2002 to 80 years for men and 84 years for women for the period 2007 – 2009, an improvement in life expectancy of nearly three years in seven years. For the period 2007 – 2009, British Columbia had a life expectancy of 80 years for men and 84 years for women while
Newfoundland experienced a life expectancy of 77 years for men and 81 years for women, a difference of three years between the provinces (Statistics Canada, 2012).

Canada ranked 10th among 34 OECD countries in 2008 with a life expectancy of 80.7 years. Japan ranked first with a life expectancy of 82.7 years; Australia reached 81.5 years and France 81.2; the UK achieved 79.7 years whilst life expectancy for the USA stood at 77.9 years (Organisation for Economic Cooperation and Development, 2011). While Canada’s life expectancy is one of the world’s best, Canada could further improve its life expectancy by increasing the performance of its health systems and with a stronger focus on population and public health and intersectoral action towards healthy behaviors, prevention of non-communicable diseases and by addressing the social determinants of health.

As Lewis mentioned in a recent article, “Canadian healthcare continues to be an underachiever” (Lewis, A System in Name Only – Access, Variation, and Reform in Canada’s Provinces, 2015). The Commonwealth Fund released the 2014 International Health Policy Survey of Older Adults in Eleven Countries in November 2014 (Osborn, Moulds, Squires, Doty, & Anderson, 2014); this provides interesting comparisons on health systems’ performance for adults aged 65 or older. For simplicity, Table 1 presents data for Canada, France (a high performer), and the United States (our neighbor) on four important performance measures of the health system from a patient’s perspective. Nine percent of Canadian senior citizens spent over $2000 out-of-pocket in the previous year compared to 0% in France. Only 45% could get a same- or next-day appointment with a doctor or nurse when needed (83% in France). Only 41% could access after-hours care (compared to 69% in France). And 39% of older Canadians had to use the emergency department in the past two years compared to only 15% in France.

Table 1. Four health system performance measures from a patient’s perspective

<table>
<thead>
<tr>
<th>Issue</th>
<th>France</th>
<th>Canada</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spent $2,000 or More Out-of-Pocket in the Past Year</td>
<td>0%</td>
<td>9%</td>
<td>21%</td>
</tr>
<tr>
<td>Could Get Same- or Next-Day Appointment with Doctor or Nurse When Sick or Needed Care</td>
<td>83%</td>
<td>45%</td>
<td>57%</td>
</tr>
<tr>
<td>Access to After-Hours Care</td>
<td>69%</td>
<td>41%</td>
<td>55%</td>
</tr>
<tr>
<td>Emergency Department Use in the Past Two Years</td>
<td>15%</td>
<td>39%</td>
<td>39%</td>
</tr>
</tbody>
</table>

Source: Commonwealth Fund 2014. International Health Policy Survey of Older Adults in Eleven Countries (Osborn, Moulds, Squires, Doty, & Anderson, 2014)

Under the Affordable Care for All Act, the United States is making rapid progress in reforming its health system. Population coverage is expanding and the growth in America’s healthcare spending is slowing. Increasingly, accountable care organizations are emerging and offering more integrated and coordinated care at lower costs (The Economist, 2015; The Economist, 2015; Townsend, 2013). High performing health organizations such as Kaiser Permanente and Intermountain Healthcare provide many useful lessons for healthcare across Canada. The need to learn from such high performing American organizations was raised by many of the senior leaders participating in the study. It was mentioned that an in-depth study of these organizations would be useful to see which of their success factors can be applied in the Canadian setting.
The following issues were raised as particularly relevant:

- access to client-centered care, clients taking charge of their own health destiny, and health and wellness promotion;
- coordination and integration of services;
- supporting electronic health records and integrated information systems together with mobile applications for patients/clients;
- integrating physicians into the accountability of care with performance-based funding and relevant modes of remuneration; and
- including financial coverage of essential drugs, particularly in the ambulatory and home care settings.
MAJOR FINDINGS

Trends in regionalization across Canada

Towards a two-level system

Recognizing the usefulness of regions, there has been a convergence of regionalization models across Canada with most provinces moving towards a two-level system in which the ministry of health provides policy, financing and overall governance and oversight, and RHAs are responsible for regional governance (in line with provincial policies), management and service delivery for a given territory and population. Ontario is the notable exception across the country.

Ontario’s system is structured between a two-level and a three-level system. The province has maintained local hospital boards, has a strong focus on access and quality, and has instituted Local Health Integration Networks (LHINs), which carry out certain integration and coordination functions but are not regions in the true sense of the word. According to some study participants, the success of the LHINs has been related more to their convening power and the leadership of their management, given the limited devolution of powers from the ministry.

The two-level system has proven very functional in several provinces including British Columbia. As of April 1, 2015, Québec moved to a two-level system as well.

Optimal size

Several study participants expressed the view that the size of regions is relevant to their functioning. A population size between 350,000 and 500,000 was deemed optimal, with road travel times within the region not exceeding three to four hours. This is consistent with the approach recommended by the WHO and other multilateral agencies (Tarimo, 1991; World Bank, 1993).

Participants felt that the current Quebec regions are well adapted to Quebec’s geography and population and that their geographic stability over the past three decades has considerably facilitated health analysis, planning, service delivery, public health and intersectoral action. It has also facilitated the ownership and health governance by the Cree and the Inuit in their respective regions.

Study participants also appreciated the regional structure in British Columbia and its stability; it was noted that the new First Nations Health Authority (FNHA) is now responsible for the health of First Nations and covers the entire province, ensuring greater ownership by the First Nations and a recognition of the specific health needs of First Nations peoples. At the same time, some study participants felt that BC’s regions were geographically very large with travel distances of 7-8 hours or more during winter driving conditions and that perhaps more numerous and smaller regions might prove more workable for a province of nearly 5 million people.

The fact remains that different services are optimally organized and delivered on different scales and to different population sizes. Some, such as primary care, are best managed and delivered at the local level to population sizes in the thousands. Other, more specialized services such as primary specialties (e.g. general surgery, pediatrics, etc.) are more appropriately delivered at the sub-regional or regional levels to sizes of tens or hundreds of thousands. Tertiary care (e.g. neurosurgery, level 3 newborn care, etc.), on the other hand, requires population sizes larger than one million and is often shared between regions. Provinces have taken on similar – but distinct – approaches to address tertiary care. In British Columbia, for instance, the Provincial Health Services Authority (PHSA) coordinates the delivery of specialized services between the RHAs. In Quebec, the four Réseaux Universitaires Intégrés
de Santé (RUIS) take on this role and are each coordinated by one of the province’s four Faculties of Medicine. And in Ontario, provincial programs such as Cancer Care Ontario coordinate the delivery of specialized cancer services across the province.

**Better Health: better than before but variable and partial**

There was a strong consensus among study participants that, building on the Lalonde Report (Lalonde, 1974) and the Ottawa Charter for Health Promotion (World Health Organization, Health and Welfare Canada, & Canadian Public Health Association, 1986), regionalization has contributed positively – albeit variably – to an enhanced population health approach. As can be seen in Figure 3, this enhanced population health approach has led to better care, enhanced public health and increased focus on intersectoral action at the regional level. These in turn have together led to an improved health status of the populations of regions, in other words to the better health part of the Triple Aim. Regionalization has also contributed to better value through enhanced relevance, priority setting, effectiveness and efficiency of the system. Regions play a key role as Integrators towards the Triple Aim.

**Figure 3. Regions as Integrators towards Health Improvement**

**Better Care: better than before but variable and partial**

Respondents from nearly all provinces agreed that regionalization has contributed to significantly better care.

The population health approach that has accompanied regionalization has contributed to a better understanding of the population health status and needs of regions and of communities. An increased reliance on evidence-based approaches has contributed to regional service delivery plans which ensure the relevance of care and better respond to the needs of communities, while allowing services to be regrouped to foster enhanced quality, improved health outcomes, lower unit costs and the achievement of critical physician team size for clinical sustainability. Examples of such regroupings were given in obstetrics & newborn care, hip and knee surgery, cardiac care and cancer care. These evidence-based approaches have additionally allowed for the establishment of single standards of care across multiple institutions, further contributing to enhanced quality of care. There was also a greater ability, albeit limited at times, to reallocate resources to priority areas.
The implementation of these regional service delivery plans, together with improved telehealth and specialist outreach services, has contributed to improving access to specialized care in rural areas of provinces.

Organizational capacity has also been enhanced in regions. The development of clinical networks and enhanced clinical governance have contributed to both improved access and to a quality improvement culture. Much more work remains to be done in the area of clinical governance of health systems in Canada.

Québec included in its regional service delivery plans the medical human resources plans (plans d’effectifs médicaux), which have contributed significantly to an improved geographic distribution of physicians across the province (Bergevin & Demers, 1986).

Regionalization has fostered greater coordination and integration of care, together with some reallocation of resources towards ambulatory, home, community and long-term care. These are particularly important considerations given the aging population and the increase in the number of Canadians living with one or more chronic conditions.

**Better Value: better than before but variable and partial**

Regionalization often occurred in the context of fiscal restraint. A prevailing view amongst politicians and senior Ministry officials was that regionalization would contribute to reducing costs. The consensus opinion from study participants was that regionalization per se may not have contributed to reducing costs. Rather, regionalization has led to more efficient systems, delivering better healthcare within existing envelopes.

Specific examples of improved effectiveness and efficiency included:

- evidence-based, relevant, rational, regional service delivery plans.
- evidence-based resource reallocation to better meet the needs of communities.
- regrouping of clinical services, increasing volumes, improving quality of services through improved clinical service expertise and the use of standards of care, leading to reduction of complication rates while lowering unit costs.
- reallocation of resources from acute care to ambulatory, home, community and long-term care.
- in some cases, better approaches to primary care, with shifts from fee-for-service payments towards capitation and other modes of physician remuneration and the use of a mix of health professionals in primary care.
- lower management costs documented in some instances.
- long-term reductions of healthcare costs through the promotion of wellness and healthy lifestyles and the prevention of non-communicable diseases. These have been achieved by health professionals during individual patient encounters and through enhanced public health and intersectoral action.
Citizen engagement: both plusses and minuses

The impact of regionalization on citizen engagement was reported to be mixed and at times more negative than positive.

On the positive side, the enhanced population health and intersectoral approaches have increased attention to the needs of communities and facilitated dialogue with elected municipal officials and community representatives. Specifically, efforts have been made to engage Indigenous peoples in the governance of their health systems, particularly in British Columbia and Quebec.

On the negative side, the dissolution of hundreds of local hospital, health centre and other institutional boards through their consolidation into one RHA has reduced citizen engagement in governance at the local level. Some commented that this poses a risk of “bureaucratizing” RHAs and their facilities, as well as the risk of excessive centralization of decision-making to provincial ministries of health. Such decreased citizen involvement may also affect the ability of hospital foundations to raise funds for specific facilities. Most agreed that this issue was sufficiently important to be studied further.

Incomplete results-driven program approach, with unclear goals, targets and weak monitoring systems

According to the Canadian Institute for Health Information (CIHI), in 2014, total healthcare spending was projected to exceed $200 billion (more than $6,000 per Canadian), representing 11% of Canada’s GDP (Canadian Institute for Health Information, s.d.). In any country, and in Canada in particular, one would think that proposing such a public health care system without clear goals, targets, baselines, benchmarks, a sound monitoring system, a clear theory of change and logical framework, feasible and scalable evidence-based cost-effective interventions and external evaluations, is unthinkable.

While there has been some recent progress, several study participants commented that until recently health service delivery had not been managed as a results-driven health program with all the required characteristics mentioned above. The situation remains variable across Canada. To be fair, many regions have developed regional service delivery plans and have multiyear plans with some indicators. The important finding here is that this is not the norm and that the stewardship of the system is sub-optimally guided by partial, provider-oriented program planning and management. The situation is compounded by a weak and variable feedback loop – the health information system – accompanied by a slow and variable move to electronic health records, an issue to which we will return shortly. Moreover, regional accountability schemes have never fully integrated the medical component of healthcare delivery (relevance, quality, timeliness, etc.).

Engagement of physicians: improving but variable and weak

At first, it may appear rather baffling to think of a system in which the majority of healthcare costs are driven by physicians, yet in which there is such little engagement of physicians in the management of the health system and such little physician accountability for its performance. This, however, is understandable given the historical nature of the bargain between physicians and politicians during the creation of Medicare across Canada and the establishment of a publicly funded insurance program and not a health system per se.

One needs to distinguish two fundamental types of physician engagement: that of physicians as managers and that of physicians as clinicians. There has been some progress in enhancing the role of physicians as leads and co-leads for services and programs. The development of clinical networks in Alberta has been an example of physician leadership, impacting the accessibility and quality of health services while enhancing the professional environment and organizational structure.
However, most study participants noted that physicians generally feel disengaged from the system and from regionalization in particular. Most felt that the current mode of engagement, contracting and remuneration of physicians was one of the major impediments to improving the performance of health systems. Many noted that the budget envelopes for physician services and for drugs – two very large components of health budgets and important drivers of the costs of the system – are not within the envelopes of RHAs. Some even felt that this partial funding relationship between RHAs and physicians was highly detrimental to system performance.

Most mentioned the need for far greater accountability of physicians for individual patient outcomes, service utilization and system performance. Many referred to the high performing healthcare systems, to the emerging results from accountable care organizations in the United States and to examples from other countries.

**Patient-centered primary health care: variable across Canada**

Most study participants believe that access to timely, quality primary care is a major issue facing health systems across provinces and regionalization in particular. This is highlighted by the Commonwealth Fund 2014 survey, which showed that only 45% of Canadian seniors could obtain a same- or next-day appointment with a doctor or nurse when needed, compared to 83% in France. Similarly, 39% of Canadian seniors used the emergency department in the past two years compared to only 15% in France, evidence of failure of the health system to decrease the recourse to hospital-based care (Osborn, Moulds, Squires, Doty, & Anderson, 2014; Tannenbaum, 2014; Marshall, 2015).

One of the goals of health systems should be to enable people to remain autonomous in their homes and communities. The access of Quebecers to family physicians has been particularly problematic; this problem has been identified as urgent and important by the provincial government and has given rise to major legislative reform and negotiations by the government in 2015. As these changes have yet to be fully implemented at the time of writing, the jury is still out as to their effectiveness.

Ontario has focused on access to primary health care with family health teams, community health centres and more adapted modes of contracting and remunerating family physicians. The Government of Ontario has posted the following on its website:

> “The Ministry of Health and Long-Term Care and the Ontario Medical Association have developed a menu of innovative and attractive compensation models that reward family physicians for providing comprehensive care to their patients. Compensation is based on blended payments. This means that while a model may be predominantly one form of payment (e.g. capitation), it will have a blend of financial incentives, premiums and other types of payments.” (Ministry of Health and Long-term Care, 2015)

Building on Ontario’s work to strengthen primary care, the Minister of Health and Long-Term Care in Ontario released *Patients First: Action Plan for Health Care* in February 2015 (Ontario, Government of, 2015). It is to be noted that 94% of Ontarians already have a primary care provider. Furthermore, for those 5% of patients with multiple and complex conditions and who account for nearly two thirds of healthcare costs, the government of Ontario has created Community Health Links to foster more coordinated and integrated care (Ministry of Health and Long-term Care, 2015). While there has been progress in Ontario, much remains to be done to ensure integrated and coordinated care, many patients ending in the hospital emergency department needlessly.
Other provinces are also actively working to strengthen access to primary health care, the cornerstone and most usual point of entry to healthcare across Canada (The Conference Board of Canada, 2014).

Building on a strong history of general practice, Canada is in the forefront of the development of family medicine education. The College of Family Physicians of Canada promotes competencies through accredited residency programs and Certification Examination in Family Medicine (CCFP) and has promoted “Timely Access to Appointments in Family Practice: Same-Day/Advanced Access Scheduling” and “A Vision for Canada: Family Practice: The Patient’s Medical Home” (The College of Family Physicians of Canada, 2011; The College of Family Physicians of Canada, 2012). Passing the Certification Examination (CCFP) has become a pre-requisite for family practice in some provinces. A number of provinces have begun moving, albeit slowly, towards family health teams and local health centres/family medicine centres (patients’ medical homes).

Several participants noted the need to enhance the focus on client-centered care and the importance of the local level and proximity services (“soins de proximité”), important considerations in the context of regionalization.

**Slow and variable progress on information systems and on electronic health records**

As mentioned in the section *Incomplete results-driven program approach*, the development of health information systems across Canada has been slow with variable progress.

Furthermore, two major problems confront the system:

1. The lack of standardization across regions within provinces and between provinces across Canada, making it difficult to make comparisons of performance;
2. The slow progress in adopting electronic health records, combined with their lack of interoperability with health information systems, make it much harder for the system to develop patient-centered, integrated and coordinated care across the continuum and to ensure continuous quality improvement of services.

Some study participants, compared this situation with the performance of an organization such as Kaiser Permanente. Not only are its electronic health records and information systems fully interoperable, but clients are equipped with a mobile application that allows them to optimally navigate the system, and which includes reminders for appointments, useful addresses, prescription drugs and other treatment programs, not to mention the wellness components of the application (Kaiser Permanente, n.d.). To keep things in perspective, Kaiser Permanente serves 9 million people and has 17,000 physicians, not that dissimilar to the population and physician numbers in large Canadian provinces (Collège des médecins du Québec, 2014).

**The frequent reorganization of the healthcare delivery architecture and of regional structures and functions within provinces**

Many study participants noted that in several provinces, provincial governments have implemented changes to regional structures and functions every few years. These frequent changes – and poorly executed change management – have caused major disruptions to the system, taking precious time away from client-focused improvements in health service delivery in order to manage the changes. As
such, any meaningful assessment or evaluation of the impact of these changes have been prevented. On
the other hand, many noted that some of these changes have been necessary to improve the healthcare
delivery system. Several respondents appreciated the fact that most provinces have now moved to a
two-level system and that provincial healthcare delivery systems are now reaching a stage of stability
and maturity.

**Insufficient clarity in roles and responsibilities of governments / ministries of health and of regional health authorities**

Study participants noted that over the past decade, functions have been devolved to RHAs without
a commensurate readjustment within the ministries of health (absence of business process
reengineering), often leading to duplications of function and to a tendency by ministries to
micromanage regions.

There was strong consensus that roles and responsibilities should be very clear:

- The government and the ministry of health should set policies, ensure financing and provide
  overall governance and oversight for health, as well as foster a whole-of-government, cabinet-level
  approach and intersectoral action towards wellness and in particular the prevention of non-
  communicable (chronic) diseases and injuries.

while

- Regional health authorities should ensure regional governance in line with provincial policies
  and take on the responsibility of management and actual service delivery, public health and
  intersectoral action within their regions.

While study participants understood the need for oversight by an elected government, there was
agreement that governments often tend to get too involved in the management of health service
delivery within regions, causing significant disruptions. Most felt that the system performed best when
the government remained at arm's length from service delivery and when communication channels
between the Board Chair and CEO of the region on the one hand, and the minister or senior civil
servants on the other, were used to address specific issues, including those raised by elected officials.

**Inadequate financial coverage of essential drugs in ambulatory/home settings**

Regional health authorities are mandated to ensure the provision of client-centered care within
communities and to promote the autonomy of clients, making the recourse to hospital care necessary
only when other approaches have failed. Several study participants mentioned that the inadequate
financial coverage of essential drugs in ambulatory care settings is a major roadblock to maintaining
people in the community and to the optimal use of non-hospital services, thus contributing to
overutilization of hospital services and driving healthcare costs up. Many felt that reimbursing the cost
of essential drugs in all settings would in fact pay for itself, especially in the context of bulk negotiating
and purchasing by provinces. This would greatly facilitate the work of RHAs to making further
progress towards ambulatory, home and community care.

In summary, Canadians enjoy one of the highest life expectancies in the world, lagging only 2 years
behind Japan, the best performer. The life expectancy of Canadians has increased nearly 3 years in the
past seven years, testimony to rapid progress. Regionalization has most likely contributed to this better
health through better care, stronger public health and increasing intersectoral action to better address
the determinants of health. Regionalization has also most likely contributed to better value for money
in health.
However, we must not shy away from taking note of the serious problems confronting healthcare in Canada. Access to family physicians and to primary care is a major issue in Québec and most other provinces and territories; wait times for specific procedures are very long in some provinces and go well beyond established benchmarks (Canadian Institute for Health Information, 2014). Total healthcare spending was projected to exceed $6,000 for every Canadian in 2014. Value for money could be improved considerably, especially when one compares Canada’s performance with that of other countries. Canada faces real challenges in measuring its performance in health and acting on results despite the existence of excellent knowledge organizations and academic institutions.

Given the very solid base in Canada’s health system development – including the major contributions from regionalization – and the well circumscribed nature of the issues facing healthcare across the provinces and territories, this report demonstrates that much progress can be made within a few years by addressing a limited number of “system” issues.

Study participants were asked to identify what it might take to further enhance the performance of regions towards better health, better care and better value. These views have been summarized in a “way forward”, to identify a vision for regionalization and to posit seven areas for improvement. These seven areas for improvement will obviously have to be discussed, debated and refined following the publication of this report.
WAY FORWARD: A VISION FOR REGIONALIZATION AND SEVEN AREAS FOR IMPROVEMENT

A Vision for Regionalized High Performing Health Systems in Canada

Decades of work in more than 100 countries shows that regions\(^1\) can provide the opportunity to achieve two aims: a high-performing health system and a territory to achieve population health improvement. By using a population health approach, regions can be powerful integrators of efforts to improve health and healthcare. On the care side, integration and coordination can best be achieved at the regional level, while focus is simultaneously maintained on specific local needs within the region.

Building on the findings of the scoping review and the interviews, a vision for regionalized high performing health systems in Canada, towards the triple aim of better health, better care and better value is provided (Figure 4). This vision reflects recent developments in health policy in high performing health systems around the world, including accountable care organizations in the United States.

Figure 4. A Vision for Regionalized High Performing Health Systems in Canada

Clarity of functions, roles and accountabilities should be re-established and respected:

- Governments and ministries of health should set policies, ensure financing and provide overall governance and oversight for health; they should also ensure a whole-of-government, cabinet-level approach and promote intersectoral action towards better health, and in particular to improve population health and the prevention of non-communicable (chronic) diseases and injuries; they should additionally ensure the provision of province-wide tertiary care through academic health centres, ideally through specific provincial/academic health authorities.

\(^1\) also called districts by WHO and by many countries
while

- Regional health authorities should ensure regional governance in line with provincial policies and take on the responsibility of management and actual service delivery, population and public health and intersectoral action within their regions.

The governance function of regions is particularly important to ensure an optimal adaptation of programs and resources to the specific needs of communities and characteristics of regions, as well as to meet the realistic expectations of key stakeholder groups. Regional governance is also necessary for regions’ efforts to engage and involve citizens and elected officials in health-related issues.

Regional health authorities should be held accountable for implementing their multi-year health plan and program. This regional plan and program should have clear goals, targets, baselines, benchmarks and a strong monitoring system. It should include the following components: service delivery (with physician human resource planning), population and public health and intersectoral action.

Two major streams of work are recommended:

- a much greater focus on population health (including population-based planning, service delivery, public health and intersectoral action)
- a renewed focus on the local level and proximity services with integrated and coordinated primary healthcare provided by highly accessible multidisciplinary family health teams/health centres

Three strategies would underpin these areas of greater focus:

- visionary executive leadership which advances a population health approach
- stronger physician leadership, engagement and accountability for clinical and health system outcomes
- stronger patient, citizen and community engagement

Such an approach would be supported by a knowledge function through an enhanced evidence-based approach, information systems and an adaptive capacity to ensure continuous learning and quality improvement. Information would flow in real time through the system with interoperable electronic health records feeding into the population-based health information system. Physicians, managers and executives would be held accountable for results.

Financial coverage of essential drugs would be provided in ambulatory and home settings, further decreasing the recourse to hospital care.

Organizing services in this manner under one regional health authority enables the reallocation of resources between acute care, long-term care and primary care/home care/social services, thus ensuring that the system is well prepared to meet the long-term care challenges of the future.

While such a vision may a priori appear unreachable or utopian, it is to be noted that high performing healthcare organizations in the US such as Kaiser Permanente and Intermountain and those in other countries are approaching such a vision, at least on the care side. Furthermore, if one were to combine the best characteristics of health regions across Canada, one would likely achieve such a vision. Such a vision is realistic in the near term for Canadian provinces and territories.
Based on the recommendations of the study participants, the following are seven areas for improvement which, if implemented, would contribute importantly to achieving this vision. While these seven areas for improvement are each necessary for regions to achieve better health, better care and better value, several will require system changes beyond regionalization. These are:

1. Manage the integrated regionalized health systems as results-driven health programs transforming them into high performing health systems
2. Strengthen wellness promotion, population and public health and intersectoral action for health to better address the social determinants of health
3. Ensure timely access to personalized primary health care/family health and to proximity services
4. Involve physicians in clinical governance and leadership, partner with them in accountability for results and engage them in the required changes to physician contracting and remuneration
5. Engage citizens in shaping their own health destiny and their health system
6. Strengthen health information systems, accelerate the deployment of electronic health records and ensure their interoperability with health information systems
7. Foster a culture of excellence, learning, innovation and research and encourage adaptive capacity towards continuous quality improvement

1. **Manage the integrated regionalized health systems as results-driven health programs transforming them into high performing health systems**

In order to achieve high performance, regionalized health systems will need to be managed as results-driven health programs with clear goals, targets, baselines, benchmarks and milestones, as well as a strong performance monitoring system with clear indicators and support from solid real-time information systems.

These systems should be characterized by robust accountabilities and metrics: physicians, managers and executives of RHAs should be held accountable for the health outcomes, utilization and value for money of their respective clienteles/populations.

Furthermore, regions should have multiyear strategic/business plans including regional service delivery plans and medical staffing plans.

2. **Strengthen wellness promotion, public health and intersectoral action for health to better address the social determinants of health**

Every opportunity to engage patients in shaping their own health destiny should be taken. This should be achieved in partnership with health professionals and by encouraging population health strategies and the adoption of healthy behaviors, preventing to the greatest extent possible chronic conditions and injuries, and promoting healthy living and aging.

Population and public health should be strengthened at regional and provincial levels, while differentiating which actions are best conducted locally (and often in partnership with municipalities and community groups), and those which are better conducted regionally or provincially. Intersectoral action for health at local, municipal, regional, provincial and federal levels should simultaneously be strengthened using approaches that are best suited for the issues at hand and through the engagement of elected officials and community representatives.
3. Ensure timely access to personalized primary health care/family health and to proximity services

Building on Canada’s strong tradition and excellence in family medicine education, every Canadian should be ensured access to timely, appropriate, comprehensive, and high quality primary care. We should continue to encourage inter-professional family practice teams comprising nurse practitioners, family physicians and other health professionals with a responsive appointment system, after-hours coverage, home care/visits as needed and coordinated and integrated care, especially for those who need it most (Spitzer, et al., 1974). These family health teams should ensure continuity of care and foster attachment.

Learning from high performing organizations and from other countries, funding for these family health teams/health centres should be results-based and not simply fee-for-service (Marshall, 2015; Burwell, 2015; Atun, 2015). Regions will need to re-focus their attention to the local level by way of proximity services (“soins de proximité”), enhanced citizen engagement and local intersectoral action in collaboration with municipalities and community groups.

4. Involve physicians in clinical governance and leadership, partner with them in accountability for results and engage them in the required changes to physician contracting and remuneration

Building on recent progress in clinical governance, physicians should be much more involved as leads for clinical services and be held accountable for results of the clinical services they lead. Clinical governance in this case is optimally achieved by physician leads/co-leads who display strong leadership and who foster motivation and teamwork. Strengthening quality of care and clinical excellence also requires the development of strategic clinical networks that connect individual clinical services within and across regions.

Beyond that, individual clinicians should be held accountable for their patients’ outcomes and co-accountable for the performance of the health system. Modalities of contracting and remuneration will need to reflect this new reality. While provincial medical associations have resisted such approaches in the past, there is an evolution towards remuneration models other than simply fee-for-service. It is to be noted that physicians in organizations such as Kaiser Permanente and in other jurisdictions achieve a high level of professional satisfaction and remuneration commensurate with their expertise and workload under performance-based funding. Remuneration should be adapted to the diversity of functions: patient care including on-call coverage; management; and teaching and research. One is reminded of the wisdom of Sidney Lee’s Three Layered Cake which was published in the 1970s and which describes a remuneration scheme consisting of three layers: basic compensation, personal incentives and system incentives (Lee SS, The Three-Layered Cake – A Plan for Physician Compensation, 1974; Lee SS, Paying the doctor: the three-layered cake revisited., 1975). We would do well to learn from experiences across provinces and from recent changes in the reimbursement system for Medicare in the US and other countries (Pear, 2015; Bras & Duhamel, 2008). In this context, a strong argument can be made to regionalize budget envelopes for the remuneration of physicians, whether it is for family physicians operating within family health teams/centres, for family practice and specialist services in hospitals or for other specialized ambulatory services. Integrating physicians within regionalized structures and functions in this manner will ensure that integration reflects the notion of the production process within an organization, a key, but often neglected management principle (Coase, 1937).
5. Engage citizens in shaping their own health destiny and their health system

As Eric Topol suggests in his book *The Patient Will See You Now*, we need to ensure that citizens are much more engaged in shaping their own health destiny in partnership with their health professional (Topol, 2015). Their engagement in the governance of their local and regional health system should be fostered.

Citizens should not only be involved in the formal governance of the RHA, but also have the opportunity to participate in local citizen/patient committees linked with their community health teams/centres, as well as in intersectoral action for wellness and the prevention of non-communicable diseases and injuries (dangerous intersections, speed limits in neighborhoods, the development of bicycle paths, school fitness, etc.). Regional health authorities should also strengthen patient advocacy and representation mechanisms at all levels of the system.

Regional health authorities should strengthen dialogue with elected municipal officials and with other community representatives.

6. Strengthen health information systems, accelerate the deployment of electronic health records and ensure their interoperability

In order to provide client-centered, integrated and coordinated care and improve the performance of the health system, electronic health records which feed a real-time population-based health information system should be fully deployed, as is currently being done in high performing healthcare organizations.

While this will require additional funding during the deployment and upgrade phase, such a system should greatly improve the efficiency of health service delivery, prevent duplication and unnecessary procedures, avert potentially dangerous drug interactions and support the maintenance at home and in the community of individuals who might otherwise end up in the emergency room and require hospitalization. All this should lead to recurrent cost savings, which should ultimately recover the deployment and upgrade costs of a full integrated electronic health records and information system.

7. Foster a culture of excellence, learning, innovation and research and encourage adaptive capacity towards continuous quality improvement

In order to foster excellence, the passion for care needs to be rekindled by involving and motivating health professionals and their professional bodies, and by fostering an approach of continuous quality improvement in all health service delivery and public health institutions. This will require effective leadership of ministries of health, RHAs and other health organizations, as well as nurturing a partnership with physicians in the context of enhanced accountability for results for their patients and the populations they serve. Accreditation mechanisms and continuous quality improvement strategies can contribute significantly to this effort. Provincial ministries of health should hold regions accountable for these results.

As knowledge is global, we should learn from the best of each system, both within Canada and internationally, and address the priority issues and areas for improvement discussed in this report.

We should strengthen innovation and research programs which can contribute to improving the Canadian health systems. This can be achieved through a coordinated effort of the Canadian Institutes of Health Research (CIHR), provincial research funds, academia and provincial ministries of health/regions with a view to addressing the issues and areas for improvement outlined in this report. We will
need greater emphasis on and more investment in implementation research closer to the delivery of services, as well as in population health interventions, fostering a culture of learning systems.

It will be important to emphasize increased inter-regional and inter-provincial learning and implementation of innovations and best practices.

Emerging high performing Accountable Care Organizations in the United States and elsewhere should be studied with the specific objective of learning what could realistically be applied to the Canadian healthcare context to bring about major improvements.

**Implement these seven areas for improvement through actions at the most relevant level(s)**

These seven areas for improvement will need to be implemented, as appropriate, by the provinces and/or RHAs, taking into account their respective roles and functions (Figure 5).

**Figure 5. Distribution of roles between provincial and regional levels**

<table>
<thead>
<tr>
<th>Provincial Population Health Policy Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Whole-of-Government approach to Better Health with prevention of non-communicable diseases and injuries</td>
</tr>
<tr>
<td>• Health Policy / Financing / Oversight</td>
</tr>
<tr>
<td>• Provincial Public Health</td>
</tr>
<tr>
<td>• Tertiary Care / Academic authorities</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Accountability Framework</th>
<th>Clarity of roles</th>
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</thead>
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<table>
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<tr>
<th>Regional Health Authority</th>
</tr>
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<tbody>
<tr>
<td>• Local / Proximity Primary Health Care / Family Health</td>
</tr>
<tr>
<td>• Secondary Care</td>
</tr>
<tr>
<td>• Coordinated and Integrated Care across the Continuum</td>
</tr>
<tr>
<td>• Regional Public Health</td>
</tr>
<tr>
<td>• Regional / Municipal Intersectoral Action</td>
</tr>
</tbody>
</table>
CONCLUSION

The recent book *Paradigm Freeze. Why it is so hard to reform health-care policy in Canada* leaves us with the impression that change in healthcare in Canada will be very difficult (Lazar, Lavis, Forest, & Church, 2013).

This study provides a different conclusion. Canadian provinces and territories are each pursuing a path to improve their healthcare systems. The vision and areas for improvement identified in this report are straightforward and could lead to significant progress towards better health, better care and better value in a only a few years, at modest one-time costs recuperated with recurrent cost savings.

All these seven areas for improvement will require strong stewardship of provincial health systems and RHAs. Area of improvement 4 which addresses physician engagement, contracting and remuneration, will require political courage. It is opportune to remember in this context, the high degree of motivation, engagement and professional satisfaction of physicians in accountable care organizations such as Kaiser Permanente or Intermountain. The recent changes to Medicare in the US towards performance-based funding demonstrates the leadership of the Government of the United States in this area.

The recently published Naylor Report emphasizes the need for meaningful change, the importance of innovation towards a better performing health system and the importance of well-documented experimentation (Government of Canada, 2015).

This report and its recommendations constitute one step towards such innovation and change.

Following Canada’s federal election in October 2015 and the election of a new Liberal government, the Prime Minister of Canada instructed the Minister of Health through her Minister of Health Mandate Letter to:

> “Engage provinces and territories in the development of a new multi-year Health Accord. This accord should include a long term funding agreement …” (Trudeau, 2015)

A renewed health accord is a unique opportunity to strive for the triple aim, be innovation-driven and performance-based. It is hoped that this Report will contribute to the deliberations shaping this new accord. Canada’s new federal Minister of Health has already indicated that throughout her career, she has been guided by the Triple Aim of Better Health, Better Care and Better Value and has expressed a desire to advance these goals for all Canadians (Philpott, 2016).

In parallel, provinces and territories might wish to hold policy dialogues to discuss the findings and implications of this Report and then shape plans to implement the areas for improvement which they deem relevant to their specific situation, as they strive towards the Triple Aim.

This study, tapped into the tremendous goodwill and sense of mission and care among the study participants. The areas for improvement presented in the Way Forward should fall on fertile ground if well communicated and if health professionals are engaged in finding solutions. Implementing these areas for improvement should increase the contribution of the health system across Canada in improving the health of Canadians and in achieving more value for money in healthcare spending in a few short years.
REFERENCES


Canadian Institute for Health Information. (2013). Health Spending in 2013. Ottawa: Canadian Institute for Health Information.


Quebec National Assembly. (2015). Bill 10: An Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies. Quebec Official Publisher.


ANNEX 1. OPEN-ENDED QUESTIONS FOR INTERVIEWS WITH CANADIAN LEADERS IN HEALTH

1. What were the expectations – the hopes – of regionalization (in your particular setting – specify; and in your province)?

2. What have been the realizations/actual results of regionalization (in your particular setting – specify; and in your province)? What has been achieved through regionalization that would not have been achieved had there not been regionalization in the first place?

3. What were the real positives?

4. What were the less positives/the mistakes? What did not work or made things worse?

5. In your view, do you think that the following areas have been impacted by regionalization (short appreciation on each CFHI Action Lever):
   a. Promoting evidence-informed decision-making, and resource allocation, please describe
   b. Engaging patients and citizens
   c. Building organizational capacity and networks
   d. Creating supportive policies and incentives, fostering innovation
   e. Engaging healthcare executives, managers and providers in creating an improvement culture; specifically, how are physicians integrated in your regional structures and functions?
   f. Focusing on population health needs (including public health and intersectoral action at regional level?)

6. A. In your view, what are the conditions of success of regionalization?
   AND
   B. What would provinces/territories have to do differently to achieve better results from regionalization? (to be a higher performing healthcare system according to the triple aim (better health, better care, better value)?)

7. Are there any other thoughts on regionalization that you would like to share with us?

8. Is there anyone else whom you think we must interview?

9. Would you recommend any key documents that we should study?
## ANNEX 2. LIST OF CANADIAN HEALTH LEADERS INTERVIEWED

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
</tr>
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<tbody>
<tr>
<td>Owen</td>
<td>Adams</td>
<td>Vice-President, Health Policy and Research</td>
</tr>
<tr>
<td>Luc</td>
<td>Boileau</td>
<td>Président-directeur général</td>
</tr>
<tr>
<td>Armand</td>
<td>Boudreau</td>
<td>Consultant en gestion</td>
</tr>
<tr>
<td>Steini</td>
<td>Brown</td>
<td>Associate Professor</td>
</tr>
<tr>
<td>Tom</td>
<td>Closson</td>
<td>HQO Board of Directors, CFHI Board of Directors</td>
</tr>
<tr>
<td>Martine</td>
<td>Couture</td>
<td>Présidente-directrice générale</td>
</tr>
<tr>
<td>Yves</td>
<td>Couturier</td>
<td>Chaire de recherche du Canada sur les pratiques professionnelles d’intégration de services en gérontologie</td>
</tr>
<tr>
<td>Maura</td>
<td>Davies</td>
<td>Interim CEO</td>
</tr>
<tr>
<td>Debbie</td>
<td>DeLancey</td>
<td>Deputy Minister, Health and Social Services</td>
</tr>
<tr>
<td>Susan</td>
<td>Fitzpatrick</td>
<td>ADM</td>
</tr>
<tr>
<td>Dan</td>
<td>Florizone</td>
<td>President &amp; CEO</td>
</tr>
<tr>
<td>Joe</td>
<td>Gallagher</td>
<td>CEO</td>
</tr>
<tr>
<td>Susan</td>
<td>Gillam</td>
<td>President and CEO</td>
</tr>
<tr>
<td>David</td>
<td>Levine</td>
<td>President</td>
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<tr>
<td>Steven</td>
<td>Lewis</td>
<td>Adjunct Professor</td>
</tr>
<tr>
<td>Greg</td>
<td>Marchildon</td>
<td>Professor</td>
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<tr>
<td>George</td>
<td>McLellan</td>
<td>Deputy Minister</td>
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<tr>
<td>Paddy</td>
<td>Meade</td>
<td>Deputy Minister</td>
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<tr>
<td>David</td>
<td>Mowat</td>
<td>Chief Medical Officer</td>
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<tr>
<td>Tom</td>
<td>Noseworthy</td>
<td>Associate Chief Medical Officer</td>
</tr>
<tr>
<td>Roger</td>
<td>Paquet</td>
<td>Président du conseil d'administration</td>
</tr>
<tr>
<td>Brian</td>
<td>Postl</td>
<td>Dean of Medicine</td>
</tr>
<tr>
<td>Nancy</td>
<td>Roberts</td>
<td>Executive Director, Health Intelligence and Planning</td>
</tr>
<tr>
<td>Name</td>
<td>Title or Role</td>
<td>Organization/Position</td>
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<td>--------------</td>
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</tr>
<tr>
<td>Jean Rochon</td>
<td>Médecin Conseil</td>
<td>Institut National de Santé Publique du Québec</td>
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<tr>
<td>Rick Roger</td>
<td>Health Services Consultant</td>
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<tr>
<td>Marcel Saulnier</td>
<td>Director General</td>
<td>Health Care Strategies Directorate, Strategic Policy Branch at Health Canada</td>
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<tr>
<td>Terry Sullivan</td>
<td>Chair</td>
<td>CADTH Board of Directors</td>
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<tr>
<td>John Van Aerde</td>
<td>President</td>
<td>Canadian Society of Physician Executives</td>
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<tr>
<td>Richard Wedge</td>
<td>CEO</td>
<td>Health PEI</td>
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<tr>
<td>Jennifer Zelmer</td>
<td>Executive Vice President</td>
<td>Canada Health Infoway</td>
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