Regionalizing Planning and Resource Allocation for Health Care in Canada

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Introduction

This paper provides a preliminary examination of the use of a policy instrument for planning and implementing resource allocation strategies for health care in Canada. Over the past 20 years or so, there has been a growing concern - present in other countries too - that investment in traditional health-care resources (doctors, hospital beds and so on) was having a minor or marginal impact on the health of the populations. Such a view itself represents a shift in perspective from patient to population. While it is recognized that individual patient well-being must be understood in terms of biophysical, psychological and behavioural risk factors, that of populations must also emphasize social, economic and even political factors. Such characteristics of the health of populations are not readily amenable to the interventions of health care traditionally defined: hence the focus on the broad determinants of health (income, education, social support, environment etc. - see Ontario, 1993; Evans et al. 1994) and on allocation strategies that reflect not only these determinants but also the needs of the population based on these characteristics. In response to these shifts in ideas about health and health care, other health goals have been adopted at the federal and provincial levels in Canada. Thus while the 1970s were largely focused on equity of access to health care and better resource management, as evidenced in the summary legislation - the Canada Health Act (see Taylor, 1986), the 1980s and increasingly the 1990s, have emphasized equity of access to health (to reflect the determinants arguments) and relative reductions on expenditures in health care per se (to reflect determinants and the financially straitened times of the '90s). These policy goals, we shall see, result in a series of policy options being available to decision-makers, although it will be argued that the policy instruments available to introduce and maintain any of those options are few. Thus most options remain at the level of policy rhetoric or academic investigation, although they are likely to influence policy practice at the margins.

This paper will examine the use of a policy instrument in two Canadian jurisdictions. It must be remembered that federal legislation in health care is significant in laying out the broad parameters of provision. It outlines the principles of health-care delivery (see Eyles et al. 1991). The federal government may penalize provinces if they are seen as acting against those principles e.g. free access to medically necessary services at the point of delivery. Yet health care is a provincial responsibility and the provinces can decide what is medically necessary and to what services those from other provinces (the portability principle) are entitled. There have been some disputes but with the reduced share of the federal contribution to health-care provision, the provinces by and large determine what is provided and in what ways. They decide upon the strategies to allocate resources and on whether non-health care investments are deemed to be health-related.

Two very different provinces will be examined - the largest in population size, Ontario and the smallest, Prince Edward Island (PEI). At first sight, such a juxtaposing of these provinces seems ridiculous. The different courses adopted may in large measure been seen as a function of size and, therefore, complexity. Yet Ontario continues to struggle with managing its health expenditures and has begun to recognize that its open-ended fee-for-service system and dense hospital network do not serve well the contemporary health care needs of its population. We use it as an example of a province which has much to gain from utilizing different policy instruments that reflect the population health perspective. PEI has, on the other hand, adopted this perspective and the

instruments apparently needed to implement it : a small, limiting case can be illustrative of possibilities for larger jurisdictions. Before examining the cases, the paper will review the policy options and instruments discussed in Canada.

1. Policy Options and Policy Instruments

The policy options available to Canadian jurisdictions have largely been gleaned from provincial reports on health-care delivery or health reform (Mhatre and Deber, 1992; Hurley et al. 1994). During late 1980s and 1990s, virtually all provinces have established task forces or royal commissions to reveal the status of their health care systems and review policy options. Analyses of their reports suggest a set of common options. Thus Mhatre and Deber (1992) isolate :

- broadening the determinants of health
- intersectoral collaboration
- emphasizing health promotion and disease prevention
- emphasizing community rather than institutional care
- providing opportunities for local participation in decision-making
- devolving authority to regional units
- improving human resource planning
- emphasizing salaried and capitation remuneration systems for physicians
- establishing advisory bodies
- increasing funding to research on utilization management, technology assessment, evaluation and information systems

Table 1 shows the mentioning of these options in different provincial reports. We should note that these options are firmly located in the population health framework. But most come from planning not implementation documents. Further they provide a mix of exhortations and policy advisory functions (broadening the determinants of health) as well as structural and organizational changes that might enhance the health of populations through health-care and non-health-care investments. In fact, there exist a limited number of policy instruments to ensure the achievement of policy goals and options, namely alternative remuneration systems (to cap the physician payment budget to reallocate potentially resources to other activities), intersectoral collaboration (often through the development of integrated health systems), community as opposed to institutional investments (allocations to enhance health to non-traditional health-care organizations) and devolved authority to the local or regional level. Many of these instruments have been considered and debated but have, mainly because of the opposition of specific interest groups and little political or public will, not been implemented. No province has moved to a fully salaried or capitated payments system for physicians, although some physicians in some provinces are so paid. The organizational obstacles to horizontally, let alone vertically, integrated delivery system are massive. Horizontal integration, e.g., the presence of doctors, nurses, social workers, nutritionists etc., in one place demands specific payment mechanisms and a commitment to a team approach to health-care delivery. Vertical integration requires the linking of primary, secondary and tertiary care and if the organizational node is the hospital little may change with respect to the balance between patient care and the health of the population.

The policy instrument that has been most commonly utilized is that of devolution to regional authorities. Hurley et al. (1994) point to the different elements of restructured governance systems and the significance of the regional level (see Table 2). By and large, regional governance has been utilized mainly for advisory and planning purposes. In no instances has revenue-raising been delegated to the regional level. Yet regional governance remains a powerful and persuasive policy instrument. Embedded within it is the possibility of delivering services from a regional basis. Further, with its emphasis on the

local, it points up many of the features of democratic decision-making to which many organizations now aspire, namely accountability, knowledge of local needs and health determinants, use of local social capital, with these in turn pointing to claimed efficiency and effectiveness in service planing and delivery. Within a regional governance structure, it is also possible to provide opportunities for local participation in decision-making and to emphasize community as opposed to institutional investments, based on local knowledge. In terms of actions, regional governance may be judged in terms of its ability to allocate resources within and between sectors (health-care and non-health care).

With this background of policy options and instruments, we now turn to our two case studies - Ontario and Prince Edward Island.

2. Ontario : A Need to Regionalize ?

In recent years, Ontario has been the only province not to address the issue of resource allocation to health care. It has maintained a system of district health councils, advisory bodies made up of local politicians, providers and consumers to contribute to the planning of health care provision and delivery. It has also funded public health at the local level but this expends only 1½ per cent of the provincial health care budget. During the tenure of the left-leaning New Democratic party government (1990-5) there was consideration of moving to regional governance structures but in the final analysis there was an unwillingness on the part of the provincial government to cede authority to other structures. Since the advent of the Conservative government (1995 to present) there has been a move to reduce, or at least contain, health-care expenditures. Thus hospital budgets have been reduced and physician remuneration has been capped. Further while a rhetoric of local accountability and control has been articulated, most changes have been determined and initiated from the centre - the Ministry of Health or the Cabinet. Thus the number of district health councils has been reduced, a hospital restructuring commission appointed to rationalize the hospital system and Ministerial statements articulate policy direction. Most recently, public concerns over the state of the health care system have led to new or rather reinstated investments. These have, however, been largely to open hospital beds and to provide more remuneration for physicians. In other words, allocations have favoured traditional health-care sectors with little or no attention to non-health care investments. Yet Ontario remains committed at one level to a population health framework and to local governance and accountability. Given these trends, it seems pertinent to ask if Ontario would benefit from a regional approach ? In other words, are there local needs for care ? What are their characteristics ? And what might be seen behind the numbers ?

To answer these questions a recent study of the public health units of Ontario (Newbold et al. *in press*) will be utilized. This study adopts a population-based approach to measuring need for care. It developed three measures of such need - the standardized mortality ratio - SMR - (the number of deaths observed in a population of a unit in relation to the number of deaths that would occur if the unit population experienced the same age and sex specific death rates as the province as a whole), a socio-economic indicator - SEI - (based on the socio-economic status (SES) of a region's population in terms of that status and socio-demographics found to be significantly correlated at the provincial level with self-reported health status) and the standardized health ratio - SHR - (the level of health status of the population of a unit in relation to the levels expected if age and sex specific levels of health of the provincial population were experienced by that in the unit - see also Birch et al. 1996). Data were obtained from the Ontario Health Survey , the census and vital statistics. Some of these data are available at the public health unit (PHU) level and other at the county level. These data mismatches led to a reduction of the units that could be examined. Table 3 shows the results by PHU, with low numbers being « good » in the sense of low relative SMR, SHR (calculated in terms of poor health) and SEI (in terms of low SES). Some PHUs score under 1 on all three measures, e.g., York, Waterloo. Some score over 1 on all measures e.g., Algoma, Cochrane, Timiskiming. What the results show is, what we would expect even given the coarse-grained data, significant regional variations. There are also variations with and between the measures themselves, pointing to a complex picture that might be best explored and

understood at the local level. In other words, resource allocation for health care may be best formulated at that level. And most certainly, a strong case could also be made for planning resource allocations at the regional level. How else could the differences between SMR, SEI and SHR be taken into consideration ?

But is such a strategy of regionalization (with its accompanied instrument-regional governance) likely to occur in Ontario ? Not in the foreseeable future. Not only is the regional issue complicated by the size of Ontario, it is also made problematic by the political and bureaucratic climates (favouring central fiat and the rhetoric of integrated systems) and public opinion (shocked by reductions in traditional health-care investments to demand more resources for hospitals, clinics, physicians and nurses). Thus not only is regional governance unlikely but so too is any implementation of a determinant of health approach, perhaps best seen in the move to the local (for needs assessment and accountability) and the allocation of resources between sectors (away fro health care to other types of health-enhancing instruments).

3. Prince Edward Island - Regionalized with what effect ?

PEI were one of the last provinces to produce a health reform document. This was published in 1993(see Lomas and Rachlis, 1995). The PEI reforms were the most all-embracing of the ten provinces. The policy options outlined were largely in accord with those established in the reports of other provinces, namely :

- emphasizing primary and community-based care
- improving efficiency and effectiveness in health care delivery
- basing planning on population health and need for care
- emphasizing community empowerment and participation in decision-making
- regionalizing health-care planning and delivery
- integrating human services planning and delivery
- developing policy councils and advisory bodies

Yet unlike the other provinces, PEI acted more quickly and more radically. Regionalization occurred and regional governance, through appointed boards, was established. They also integrated the human services budget, bringing into one envelope health care, social and community services, housing and justice and corrections. In this instance, the policy instrument seemed to be clearly implemented: namely regional governance with the options of empowering local decision-making, utilizing its knowledge to address local needs and responding by making resource allocation decisions that favour non-health care investments in line with the broad determinants of health.

What has been the impact of this policy instrument ? As seems usual, they have been complicating - namely economic and political - factors. Initially, the signal that funding could be used for investing in non-health care sectors was confused as the PEI reforms came at a time when reductions were being made to all public sector budgets. Thus the instrument, usable to make cross-sectional resource reallocations, was blunt as cuts in block funding were handed down by the provincial government. Further, the regional boards still had (and have) to struggle with different financial systems - for hospitals, welfare and housing. These different financial systems have also made tracking of reallocation decisions very difficult.

Given the small population size of PEI and the placement of health care facilities in many small communities, regional rivalries (the provision of higher-tier services in particular) and service duplication (especially in the hospital sector) have made the implementation of the reforms problematic. The election of a Conservative government in the province in 1996 also led to changes, namely the removal of justice and corrections from the envelope, the refusal to close small rural hospitals (and hence lowering funds available for reallocation) and the reorganization of central components of the health systems (the closure of the policy advisory bodies). These have slowed the progress toward regional implementation. The public is also reluctant to countenance much change as it fears hospital closures and the lack of

visibility of reinvestment. Yet the new government remains committed to the reform philosophy of a population health framework, integrated, effective service provision and regional governance. This is, however, never likely to be an easy instrument to alter resource allocations as physician payments were deliberately excluded from the human services budget envelope.

Yet change is occurring and in the crucial area of cross-sectoral resource allocation. In a 1997 survey, PEI (1998) noted that while most reallocations had been within sectors, there was significant resources flowing between sectors. The regional structure though was limiting if reallocations should occur, as seems likely, between as well as within regions (see Table 4). Most of the reallocations are in fact non-financial, taking the form of the transfer of personnel from, say, hospital psychiatry to community mental health or of a facility from institution to a community site. There have been financial reallocations but most were at no « real » cost to the parties so have been largely amicably determined. So for example, welfare savings were reallocated to healthy community and job creation initiatives as well as to home care, public health and hospitals. Table 4 also points to the perceived barriers to reallocation, namely public resistance, provider pressure, lack of information on the costs and benefits of making reallocations and union resistance and/or contracts. Other items mentioned included negative staff perceptions, lack of policy direction and the power of the traditional health care sector, especially hospitals.

In sum, it may be claimed that PEI has implemented the rhetoric of reform - a regional governance structure to enhance local decision-making, community investments and a reorientation of the system to the broad determinants of health. It has made the process real by introducing a combined human services budget, albeit without physician payments. It remains too early to say if PEI will succeed in reorienting its system with its chosen policy instruments. There remain important impediments, especially the political climate, the established power of the hospital and physicians (who may or may not be in favour of reallocation) and public concerns. Further, reorientation has thus for largely been shaped by the shift of non-monetary resources. It also seems likely that those working for the success of the chosen policy instruments will require tools to help them make the decisions about regional governance and resource reallocations. Initial findings suggest that the support required is not evidential but assistance in managing conflict and dissent (PEI, 1998).

Conclusions

This paper has examined some of the policy goals and options of Canadian health care jurisdictions. It has argued that these options can only be implemented through a limited number of policy instruments. Discussion focussed on regional governance as one type of instrument, embedded within which are many of the policy options, e.g., local participation in decision-making, enhancing population as opposed to patient health. It utilized two case studies. First, Ontario was used as a case in which there has been little movement towards regional governance with reallocation decisions having been determined centrally. An argument was made for the utility of regionalization in Ontario. In the other case study, PEI has adopted the rhetoric of population health and regional governance as its reality. Progress to date was reviewed, given all the complicating factors. The jury remains out on whether regional governance will be a successful policy instrument. What is perhaps required is a consideration of other jurisdictions in Canada and how this instrument has brought them closer to (or farther from) their policy goals and a comparison between regional governance and central determination (partly prefigured in the two presented cases in this paper) for achieving the goals most provinces wish to achieve.

Table 1
Health Policy Themes Mentioned in Provincial Reports

	AB	SAS	ONT	QUE	NB	NS
Board definition of health	x	x	x	x	x	x
Intersectoral planning		x	x	x		x
Health promotion and disease prevention	x	x	x	x	x	x
Shift from institution to community	x	x	x	x	x	x
Increased participation	x	x	x	x	x	x
Regional authorities	x	x	x	x	x	x
Improved human ressources planning	x	x	x	x	x	x
Alternative methods of physician remuneration		x	x	x	x	x
Premier's Council			x		x	x
Research	x		x	x	x	x

Province abbreviations: AB, Alberta; SAS, Saskatchewan; ONT, Ontario; QUE, Quebec; NB, New Brunswick; NS, Nova Scotia

Source: Adapted from Mhatre and Deber 1992

Table 2 **Elements of Restructured Provincial Governance Systems**

Level	British Columbia	Saskatchewan	Manitoba	Quebec	New Brunswick	Nova Scotia
Provincial	Ministry of Health Health Council Composition: - unspecified	Ministry of Health Health Council Composition : 12-15 individuals representing : - consumers - urban/rural - labour/business - educators - interest groups	Ministry of Health	Ministry of Health	Ministry of Health	Department of Health Provincial Programs Advisory Committee Composition : - representatives of four regions and the Department of Health
Regional	Regional Health Board Composition - representatives of the region's community health councils - appointees of minister of health			18 Regional Health and Social Service Boards Composition: - 20 elected from regional assembly - exec director - regional medical commission representative	8 Regional Hospital Boards Composition: voting: - 3-4 appointees of minister - members selected according to regional hospital bylaws	4 Regional health Boards Composition: - 12-16 members - two-thirds nominated by community health boards; one-third appointed by minister
				- 1-2 co-opted from assembly by board 18 Regional Assemblies Composition : - up to 150 in specified prop'n representing: - institutions - community orgs - socio-econ grp - municipalities	- 2-3 others selected by board Non-voting - CEO of Regional Hospital Corp - Regional Dir of Medical Staff	- two-thirds of members to be consumers
Local	Community Health Council Boards composition : - elected community representatives - appointees of minister	Local Health District Boards Composition : - 8 elected community reps - 4 appointees of minister from community nominees				Community Health Boards Composition : - one-half of membership to be consumers - selected mechanism not specified

Source: Hurley et al. 1994

Table 3
SHRs, SMRs and SEIs by PHU : Ontario, 1990

PHU	SHR	SMR	SEI
Algoma	1.006	1.156	1.001
Brant	0.987	1.116	1.024
Durham	1.162	0.876	0.991
Elgin	0.967	1.165	0.999
Windsor	1.040	1.000	0.981
Norfolk	0.842	1.086	1.010
Halton	0.753	0.771	1.001
Hamilton	1.070	1.047	1.009
Huron	0.809	1.043	0.992
Kent	1.141	1.110	1.013
Lambton	0.841	1.016	0.995
Middlesex	0.909	0.983	1.002
Niagara	0.990	1.025	1.010
North Bay	1.237	1.238	1.009
Ottawa	0.582	0.942	1.028
Oxford	0.784	1.016	0.993
Peel	1.064	0.756	0.981
Perth	0.792	0.981	1.006
Peterborough	0.721	1.082	1.005
Cochrane	1.462	1.274	1.025
Renfrew	1.398	1.200	1.020
Simcoe	1.054	1.105	0.999
Thunder Bay	1.171	1.294	1.004
Timiskiming	1.247	1.302	1.024
Toronto	1.124	0.953	0.998
Waterloo	0.987	0.894	0.997
York	0.698	0.753	0.977

SHR = Standardized Health Ratios
SMR = Standardized Mortality Ratios
SEI = Socio-Economic Indicators
PHU = Public Health Units
Source: Newbold et al. in press

Table 4

(A) Cross-Sectoral Resource Allocations in PEI (perceptions of senior managers)

	% of managers claiming CSRA is occurring
Within health care	90
Within non-health care	79
Between health care and non-health care	77
Between regions	45

(B) Barriers to Cross-Sectoral Resource Allocation (perception of senior managers)

	% of managers seeing issues as important
Public resistance	55
Provider pressure	50
Lack of economic data (costs, benefits)	43
Union issues	24

Source: Adapted from PEI 1998

References

1 Birch, S. et al. 1996. Proxies for health care need among populations, *Journal of Epidemiology and CommunityHealth* 50, 564-569.

2 Evans, R. et al. (eds.) 1994. *Why are some people healthy and others not*? DeGruyter, New York.

3 Eyles, J. et al. 1991. A needs-based methodology for the allocation of health-care resources in Ontario, *Social Sciences and Medicine* 33, 489-500.

4 Hurley, J. et al. 1994. When tinkering is not enough, *Canadian Public Administration* 37, 490-514.

5 Lomas, J. and M. Rachlis, 1995. Moving rocks: block funding in PEI, *Canadian Public Administration* 39, 581-600.

6 Mhatre, S. and R. Deber, 1992. From equal access to health care to equitable access to health, *International Journal of Health Services*, 22, 645-668.

7 Newbold, B. et al. *In press*. Allocating resources in health care, *Health and Place*.

8 PEI, 1998. *Decision-support tools*, DHSS, Charlottetown.

9 Taylor, M. 1986. The Canadian health care system 1974-84, in R.G. Evans and G.L. Stoddart (eds.) *Medicare at maturity* University of Calgary Press, Calgary.