Health Systems Restructuring In Ontario:

Public Participation and Regionalization: The Un-Traveled Road

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ABSTRACT

Throughout the past twenty-five years, the provision of publicly funded health care has been the most dominant public policy debate in Canadian society. There are numerous research papers and other analyses that offer solutions and recommendations in the provision of an efficient and effective health care delivery system. The tension between efficiency, and the need for cost containment, and effectiveness, and the need for citizen involvement, in the health service system is explored through a discussion of the major policy option for health care restructuring. Utilizing an extensive literature review, case studies, theoretical literature and personal interviews the phenomenon of regionalization is explored and considered within the context of the healthcare restructuring efforts in Ontario. Is regionalization the next step for the health care system in Ontario?

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I. INTRODUCTION

It can be argued that throughout the 1990s and into the new millennium, the system of health care and health service delivery has been the dominant public policy debate in Canada. In embarking on a study of the topic, one immediately recognizes the vastness and extent of analysis, documentation and commentary that must be dealt with in order to effectively construct any type of critical research paper. In an attempt to address and understand many of the intricacies and complexities inherent in the health care system, some of the most robust and provocative democratic political theories are being applied to the concepts of healthcare governance and administration. Canadian academics are leading a field of researchers in the application of discursive forms of democracy to healthcare management. Interestingly, Canada has been praised internationally for its provision of one of the best publicly funded health care systems in the world by many of these same researchers. At the same time; however, politicians, journalists, some academics and most importantly, the Canadian public, declare that the system is in mortal crisis.[1] It is hardly a surprise; therefore, that almost annually a different Royal Commission or provincial task force brings forward a new report or recommendation designed to "reform the system".

Health care, in and of itself, is a sector filled with complexities, inter-governmental dynamics and various organizational processes spanning the full

[1] John Dorland, How Many Roads? Regionalization and Decentralization in Health Care, Queens-CMA Conference, (Kingston: Queen's University Press, 1996): 1.

spectrum of public policy options and theory. Even in the most comprehensive of research reports and analyses, one would be extremely challenged to represent the 'system' in its entirety. As Canada continues to provide a publicly funded health care system to its population, the governance and management of that system provides an excellent opportunity for analysis and discussion within a public administration framework. Even more appropriate; however, is the application of this same framework and its corresponding theoretical foundations to the management and administration of Canada's public hospitals especially in consideration of the reforms and recommendations imposed on these highly complex, pluralist, public sector organizations.

The most popular public policy recommendations, especially in terms of system-wide restructuring, often focus on the relationship between institutional governance and inter-organizational coordination and integration. Contained within that relationship is the central and fundamental role of the citizen, who, in some cases, might be a governor while in others may be the customer or patient and in even others might be the tax-payer or resident. It is this complex, and often contentious relationship that creates many interesting situations and has often become the subject of research and discussion. It is this primary relationship between the health care institution, as a decision-making structure, and the citizen that has driven the investigation and subsequent analysis of this research report.

II. RESEARCH QUESTION

Throughout the past decade, many academics, government officials and health care managers have questioned the most appropriate role for the citizen in the decision-making structures of the health care delivery system. In the province of Ontario, an unprecedented period of restructuring has completely altered traditional organizational structures with very little consideration for the public as a key stakeholder in the decision-making or health service governance process. The purpose of this research paper is to offer a critical examination and discussion of the theoretical framework driving the restructuring movement in the health services system, specifically in the province of Ontario. It will also expand on and offer an examination of "regionalization" as the primary public policy option in the reformation of health service decision-making structures. The fundamental research question for analysis and discussion throughout this paper; therefore, is as follows:

Can the governance structures of the healthcare system in Ontario integrate the principles of public participation and citizen engagement, by instituting regional decision-making health authorities in order to more effectively govern the health services system in the province?

This paper will be constructed in three sections in order to best address this complex issue. The first section of this analysis will focus on the creation of a theoretical framework and rationale. Essentially, by posing the research question above, one assumes that public participation is a goal of the health system decision-making process. Theoretically, the concept of public participation in governing systems is one of the most fundamental democratic

and political issues in modern political science; however, it is important to discuss and explore the linkages of this concept to the health care sector. Drawing from this discussion, the second section will apply this theoretical framework to the province of Ontario. Ontario provides an unparalleled opportunity for a 'case study' approach to this analysis because of the province's unique approach to system reform as a result of the Health Services Restructuring Commission mechanism. Finally, the third section of this analysis will examine both the international and national trend toward the regionalization of health care decision-making structures. As a publicly provided service, health care is arguably the most important and pressing issue in Canadian public sector administration research today. As such, a discussion and analysis of the current health service system, and considerations for future developments and restructurings in the province of Ontario, will follow the theoretical and research-oriented sections.

III. THEORETICAL ANALYSIS

A) Foundations of Public Participation

"The government of democracy makes the idea of political rights descend to the least of citizens"

- ***Alexis deTocqueville****, Democracy in America (V1, Pt II, Chapter 6)*

Considering the research question, as framed above, it is obvious that there are some underlying assumptions in the construction of this research report. Most importantly and explicitly, is the idea that public participation is, for

whatever reason, a goal or at the very least, an important concept in the development of governing structures for the Canadian healthcare system. In order to examine the relationship between public participation and effective governance structures; however, it is important to first discuss the theoretical framework and foundations through which democratic theory has evolved.

B) Roots of Democracy

The idea behind the inclusion of public participation in governance is certainly not a new theoretical concept. For centuries, political theorists have debated and discussed the role of citizens, the responsibilities of governments and the impact of this highly complex relationship in the effective governance of society. In one of the most comprehensive overviews of American democracy and democratic society, Alexis deTocqueville makes some very interesting observations about civic society and citizen involvement. DeTocqueville argues that, more than anything, those individuals who live in a democratic society desire equality. He claims, "but freedom is not the principal and contentious object of their desire; what they love is equality ... nothing can satisfy them without equality and they would sooner consent to perish than to lose it."[2] Based on this assumption, it can then be argued that equality is also the fundamental and central right of the Canadian constitutional state and therefore the foundational principle of its society. As Canadian political theorist, James

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[2] Alexis DeTocqueville, Democracy In America, (Chicago: University of Chicago Press, 2000): 1(1); Chapter 3: 52.

Tully argues, "modern constitutionalism developed over the last four centuries around two main forms of recognition: the equality of independent, self-governing nation states and the equality of individual citizens."[3] It is as a result of this conceptualization of the fundamental importance of equality as a universal right that many traditional theories of democracy and the democratic principles have been shaped. Simply stated, democracy is "government for the people by the people". As a logical extension; therefore, the democratic principles are most commonly understood as one person / one vote. It is from this basic conceptualization that traditional democratic theorists argue that all citizens are indirectly involved in the decision-making processes of government by virtue of their equal right to exercise a vote.[4] Democratic participation involves sharing power for government decision-making among all citizens equally.[5] In this perspective participation becomes a passive form of citizen involvement in governance. It assumes that because citizens are equal, they all posses the power to cast one vote. This affords all individuals the power to govern their own societies freely. Recent theoretical debates and discussions have forced a re-conceptualization of these traditional forms of democracy, participation and their corresponding hypotheses about the relationship between individual citizens and governments. The process through which society is governed is evolving

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[3] James Tully, Strange Multiplicity: Constitutionalism in an Age of Diversity, (Cambridge: Cambridge University Press, 1995): 15.
[4] Julia Abelson, "Understanding the role of contextual influences on local-health-care decision making: case study results from Ontario, Canada," Social *Science and Medicine*, 2001; 53: 777. [Hereinafter referred to as Abelson, 2001]
[5] Abelson, 2001: 777.

from traditional democratic forms to much more complex and integrated processes.

C) Evolving Democracy – Discourse and Deliberation

Throughout the 1900s political theorists began to propose new forms of democratic theory and adjustments to the basic democratic principles. Led primarily by the works of Jürgen Habermas, deliberative democracy has emerged new ideological movement. Generally deliberative democracy can be described as a process through which discourse and debate become the primary vehicles through which the decision-making process is informed. As Simone Chambers notes, in her analysis of Habermas' discourse ethics:

> Discourse ethics replaces the image of public debate as a marketplace of ideas between elites in which interests and understandings compete with each other for domination with the idea of public debate as a democratized forum in which we cooperatively construct common understandings and work through our differences...discourse ethics depends on institutionalizing the necessary procedures and conditions of communication, but discourse also depends on citizens participating in institutionalized as well as informal discourse as discursive actors.[6]

While political theorists have debated the nature of democracy for centuries, it was Habermas who introduced the concept of formalized, institutionalized and democratized citizen participation in governance. This new conceptualization of participation has had a tremendous impact on how the citizen, the community and the government relate to one another. In 1993, Robert Putnam and his

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[6] Simone Chambers, "Discourse and Democratic Practices," The Cambridge Companion to Habermas, White, Stephen ed. (Cambridge: Cambridge University Press, 1995): 247.

colleagues attempted to apply many of Habermas' ideas about citizen participation and discourse to a theory designed to link the civic nature of a community to effective governance. Essentially, Putnam relates all aspects of community relations to political governance. As Gerry Veenestra and Jonathan Lomas, two of Canada's leading health care economists, note in their analysis of Putnam's theory:

> Following deToqueville, Putnam defines a 'civic' community to be one that is marked by active participation in public affairs and where the pursuit of the public good supersedes the pursuit of private individual ends. The civic community is bound by horizontal relations of reciprocity and cooperation rather than by vertical ones of authority and dependency.[7]

In Putnam's theory, social capital[8] or the nature and extent of the civic community is the crucial element in determining the effectiveness of local governance. Veenestra and Lomas expand on this theory as they go on to posit that, because of the link they have found between social capital constructs and the effectiveness of specific governance authorities in health care, a significant shift is needed in what governments and other authorities choose to focus on when designing local governance structures.[9] Democratic theory has evolved from its traditional roots of one person / one vote to a much more participatory

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[7] Gerry Veenestra and Johnathan Lomas, "Home is Where the Governing Is: Social Capital and Regional Health Governance," *Health & Place*, 1999; 5: 2. [hereinafter Veenstra and Lomas, 1995]

[8] Social capital is commonly defined as a community's tendency towards the creation of social or community associations. Community's that tend to form many civil associations, dense networks of secondary associations or organizations that serve to instill cooperation and solidarity in citizens which then contributes to the effective social collaboration are said to have high 'stores' of social capital. Putnam et al., Making Democracy Work: Civic Traditions in Modern Italy, (New Jersey: Princeton University Press, 1993): 86-91.

[9] Veenstra and Lomas, 1995: 2.

process involving the citizenry in the decision-making processes of government. As a result, the debate and discussion now focuses on how to facilitate this new relationship.

D) Creating Effective Governance Structures

An optimistic view of well-functioning democratic societies assumes that citizens desire and expect to interact with governing authorities in decision-making about public policy and that decision-makers support this role as a necessary and important part of the process. As Julia Abelson et al, notes, "a more realistic view, understands that citizens often need to be convinced of the relevance and utility of getting involved, and decision-makers must be willing to give up some control over the process."[10] Thus, the debate about public participation in governance is not about whether or not groups agree on the importance of involving the citizenry in the process, rather the current literature seems to be more concerned with and therefore focuses on designing structures that ensure more effective and legitimate public participation processes.

E) Motivation for Participation

Having arrived at a definition, or at least the theoretical evolution, of the concept of participation in the first half of this section, it is now important to turn to the question: "why is participation a desirable goal of the health care system?"

[10] Abelson, et. al, "Obtaining public input for health –systems decision-making: Past experiences and future prospects," *Canadian Public Administration*, 2001; 45(1): 71. [Hereinafter referred to as: Abelson et al, 2001]

Generally, as discussed above, there is agreement that the citizenry should be involved in the decision-making process. Motivation for this agreement is generated from both an ideological point of view, and the desire to pursue the democratic ideals of legitimacy, transparency and accountability; and the more pragmatic position, that being the desire to achieve popular support for potentially unpopular decisions.[11] Jonathan Lomas argues; for example, that it is no coincidence that interest in public involvement in health care decisions has occurred at the same time as concern about the ability of the state to continue to fund higher levels of service. He claims that the desire of governments, managers and providers for obtaining public input is largely instrumental, and that public involvement is not a goal in itself.[12] On the other hand, Jo Lenaghan argues that due to the complexity and intricacies of health care decisions:

> There can be no right answer to questions about health care priorities. Such decisions are essentially value judgments, which will vary between individuals, groups and societies. Legitimacy, therefore, is derived from the decision-making process. This process is more likely to be seen as legitimate if it is open, if it enables different interests to contribute.[13]

Finally, in a study and discussion of public participation modes within a public administration framework, Cheryl Simrell King and her colleagues find:

> Administrative legitimacy requires active accountability to citizens, from whom the ends of government derive.

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[11] Abelson, et al "Deliberations about deliberative methods: issues in the design and evolution of public participation processes," *Social Science & Medicine*, 2003; 57: 239. [Hereinafter referred to as: Abelson et al, 2003]

[12] Jonathan Lomas, "Reluctant Rationers: public input to health care priorities," *Journal of Health Services*, 1997; 2(2): 104.

[13] Jo Lenaghan, "Involving the Public in Rationing Decisions. The experience of citizen juries," *Health Policy*, 1999; 49: 46. [Hereinafter referred to as Lenaghan, 1999]

> Accountability, in turn, requires a shared framework for the interpretation of basic values, one that must be developed jointly by bureaucrats and citizens in real world situations rather than assumed. The legitimate administrative state, in other words, is one inhabited by active citizens.[14]

Public participation in decision-making is not necessarily about making the "best" or even the "right" technical decision. It is more about ensuring legitimacy, accountability and the public interest. Underlying all of the discussions about public participation as a tool for legitimacy, accountability or even political positioning is the consideration of public participation as a tool through which "effective" decisions are achieved. Often, public policy decisions are made on the basis of efficiency, or the maximum utilization of scarce resources. The discourse around public participation in governing is not a question of how to arrive at the most efficient decision; rather, it seeks to balance the other side of the equation, that being the creation of effective decision-making structures. The definition of "effectiveness" contains legitimacy, accountability and the consideration of societal values, all of which are core motivations for public participation in this analysis. Even though governments may utilize participation as a political tool, the theory has evolved as a way to ensure the creation of effective decision-making structures.

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[14] Cheryl Simrell King, Kathryn Feltey and Bridget O'Neill Susel, "The question of participation: Toward authentic participation in public administration," *Public Administration Review*, 1998; 58(4): 319. [Hereinafter referred to as King et al, 1998]

F) Authentic Participation

Knowing that participation is a goal of the governance system and public administration framework, a great deal of the research and discussion has turned away from questions about the necessity of public participation to more structural and process oriented discussions about strategies to develop effective forms of public participation. Historically, the role of public participation has been one of ambivalence.[15] Even though the political system in many cases is designed to engender and support an active citizenry, it is also designed, to protect the administrative and political processes from a too-active citizenry and it is within this context that public participation in the public administrative framework has traditionally been framed.[16] Essentially, public participation has four major components:

1. The issue or situation
2. The administrative structures, systems and processes within which participation takes place
3. The administrators, governors or managers
4. The citizens

Traditionally, the citizen is placed at the greatest distance from the issue, the administrative structures and processes are the closest while the administrator is the agent between the structures and the citizens. In this structure the administrator defines the issue or situation and controls the ability of the citizen to impact or influence the situation or the process. Participation in this context is often conflictual and ineffective, often arising well into the process, after the

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[15] King et al, 1998: 318.
[16] King, et al, 1998: 319.

issue has been defined. In cases such as this, citizen participation is often more symbolic than real.[17]

Authentic participation; however, seeks to redefine these traditional roles and modes for public participation. Current participation research and literature emphasizes the need for a re-conceptualization of traditional governance structures in order to facilitate a two-way interaction between the decision-makers and the public through deliberative forms of democracy. As Julia Abelson, one of Canada's leading academics in the field of health care decision-making and governance, observes:

> The creation of an appropriate "public sphere" (Habermas, 1984) for dialogue has become a recent pre-occupation in the health system recently as pressures mount for governments to clarify the relative roles of the private and public sectors in funding and delivering what have historically been largely 'public goods'.[18]

Authentic participation is a process of involvement that provides all involved with the potential to have an impact on the situation. Participation; therefore, becomes an integral part of the decision-making process rather than an add-on to existing practices. The public becomes part of the deliberation from framing of the issue to the final decision-making.[19]

Essentially, what is being described is the evolution from 'passive democracy' to a more 'active democratic societal process.' Lying at the heart of

[17] King et al, 1998: 319. Figure 1 is a visual representation of this concept of traditional modes of public participation. Figure 2 is a graphic representation of a re-conceptualized, redefined process for modes f authentic public participation. It is also important to note that King et al. derive many of their theories from Arnstein's ladder of citizen participation. See also: Arnstein, S, "A Ladder of Citizen Participation," *Journal of the American Institute of Planners*, 1969; 35: 216-224.
[18] Abelson, Julia et al, 2003: 240.
[19] King et al, 1998: 320.

authentic modes of participation is a discourse where all participants have an equal footing and where one group is not privileged over another.[20] Not only does authentic participation seek to redefine the role of the citizen from a person with a vote to a person with a voice, it also seeks to re-engage the concept of equality, in so far as all citizens are free and equal within the discourse. As the discourse becomes the realm where decision-making is engaged and informed, governance becomes an active process of citizen engagement.

G) Public Participation in Health Care

What becomes evident through this analysis is that traditional forms of public participation and citizen involvement must be transformed and reconsidered. For example, simply engaging the public for opinions or reactions to decisions already made, are not true forms of deliberative participation. Participation in health care has become one of the most extensively applied concepts within the decision-making structures. In this context, participation, has taken on numerous forms and structures in different provinces, regions and even institutions. In fact, there are a considerable number of case studies, which pose the question "what are the most appropriate forms or roles for public participation in health care?" As Julia Abelson notes:

> Much of the health services research in this area [public participation] has focused on eliciting public preferences or

[20] Jürgen Habermas. Legitimation Crisis. (Boston, MA: Beacon Press, 1975).

> priorities from a list of pre-determined programs or services. This input is frequently obtained by using either a single consultation method for a particular group (e.g., citizen surveys, citizen panels). Other research has focused on evaluating the merits and deficiencies of public and community consultation exercises within a specific service sector (e.g., long-term care reform).[21]

At this point, it is important to delineate and discuss the two different types or applications for public involvement most commonly utilized in healthcare decision-making processes. There are those, which seek to involve the citizen in debating the general issues, and those, which seek to involve the citizen in deliberating upon specific policy problems or questions.[22] While both may be important, involving the public through a process of deliberation is a much more instrumental and valuable approach in the creation of effective decision-making processes. Health service rationing exercises are most effectively informed by deliberative processes involving the community. Rather than asking what the public wants in general, rationing, or the way in which finite resources are allocated, becomes the core subject for deliberation.[23] Rationing, as opposed to public opinion polling ensures that the dialogue is about "something". In fact, through the dialogue, effective decisions that reflect the underlying values are made. Traditional means of engaging the public often seek to attain what the public wants from its health care system rather than how to best utilize the scarce resources available. Rationing; therefore, becomes the most important

[21] Abelson, 2001: 778.
[22] Lenaghan, 1999: 47.
[23] Lenaghan, 1999: 47.

and central exercise in the creation of effective healthcare decision-making processes.

As Anna Coote argues, there are two main reasons for engaging the public in rationing exercises. First, a national health service must be rendered genuinely accountable to the public and second, rationing decisions are essentially political in nature. Rationing falls into the political category because rationing decisions concern the fair distribution of finite resources.[24] For the purpose of developing linkages back to the theoretical framework; therefore, according to this view, within democratic societies, citizens should be able to participate in decision making about issues, which affect their vital interests. Access to appropriate health care is clearly one of the most important of such interests.[25]

H) Summary

Accepting the assumption that public participation is a desirable goal of the health care system requires a re-conceptualization of the functional and political relationship between citizens and the administrative apparatus. Because of its importance to all citizens regardless of age, socio-economic status or any other demographic factor, healthcare and access to health services has become the primary sector in Canada for integrating the foundations of deliberative public participation theory to health care governance structures. As a result

[24] Anna Coote, "Direct public involvement in rationing." *British Medical Journal*, 1997; 64: 159.
[25] Lengahan, 1999: 47.

public participation in health care has become a desirable goal of the system as an assurance that this extraordinarily important public policy is reflective of the underlying values of Canadian society.

IV. HEALTH CARE GOVERNANCE – APPLICATION

As is most often the case, applying a theory to a practical, "real world" situation is often problematic and wrought with difficulty. Given the development of the above theoretical framework; however, it is now important to turn to a discussion of the evolution of governance structures for health care delivery organizations. For the purposes of this analysis, it is important to offer an explicit definition of governance structures. They are, "formal structures and authorities in which decision-making responsibility is held – the bodies (private or public) that have decision-making power with respect to specific activities and functions."[26] These structures are distinct from both the informal processes through which decisions are made and the management processes, which refer to mechanisms through which health care programs operate.[27] The first half of this, the second section, will turn to a discussion of the system and purpose of hospital governance in the province of Ontario, up to and including the restructuring process of the late 1990s. The second half of this section will go

[26] Jeremiah Hurley, Jonathan Lomas and Vandna Bhatia, "When Tinkering is Not Enough: Provincial Reform to Manage Health Care Resources," *Canadian Public Administration*, 1997; 37(3): 493. [Hereinafter referred to as Hurley, Lomas and Bhatia, 1997]
[27] Hurley, Lomas and Bhatia, 1997: 493.

on to examine the impact of the restructuring process on the effective governing of Ontario's health care organizations, specifically the province's hospitals.

A) Traditional Governance

For this section, it is important to first clarify that I will be specifically addressing the question of hospital governance, as opposed to system-wide governance and administration of the health care continuum, which will actually be addressed in the final section of this paper. In 1992, the Ontario Ministry of Health released the report of the Steering Committee, struck to review the *Public Hospitals Act*: Into the 21st Century: Ontario's Public Hospitals Report of the Steering Committee, Public Hospitals Act Review. In it, governance is defined as, "the exercise of authority, direction and control over the hospital by its board of directors."[28] The fundamental responsibilities and functions of the governance structure for a public hospital in Ontario are:

- Defining the purposes, principles and objectives of the hospital
- Ensuring and monitoring the quality of hospital services
- Ensuring the fiscal integrity and long-term future of the hospital
- Arranging for and monitoring the effectiveness of the hospital's management.[29]

Since the construction of the first hospitals in Canada, in the late 1600s, single hospital boards have been the selected method of governance.[30] In the

[28] Ontario Ministry of Health, Into the 21st Century: Ontario's Public Hospitals Report of the Steering Committee, Public Hospitals Act Review, (Toronto: February, 1992): 13.
[29] Mark Hundert and Rob Crawford, "Issues in the Governance of Canadian Hospitals, Part 1: Structure and Process," *Hospital Quarterly*, Fall 2002; 6(1): 64. [Hereinafter referred to as Hundert and Crawford, 2002].

province of Ontario, this method continues to be the dominant structural arrangement. Essentially, most hospitals are private entities, owned by the hospital's corporation, which is normally composed of members of the community or a religious diocese, and governed by an independent board of governors or directors. In Ontario, as was the case in all other provinces in Canada, hospital boards, while independent, are significantly dependent on the provincial government for their operating and capital funds. And although the provincial government holds hospital boards accountable for the funds they receive, they have afforded the Boards a great deal of independence and latitude in the provision of services that meet the interests and needs of their communities.[31] As Mark Hundert and Robert Crawford report, "the position of the government is that once it has agreed with the hospital's general program, it remains at 'arm's length' from the hospital's day-to-day activities unless and until a major issue occurs."[32]

As corporate entities; therefore, a hospital board's ultimate accountability is to the organization's ownership. While this may seem like a fairly straightforward concept, it is in fact, one of the fundamental flaws in the traditional hospital governance system. In the case of a church-owned hospital, military hospital or government hospital, there is a clear and discernable owner. The majority of public hospitals, which possess independent hospital boards are

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[30] Fran Brunelle, Peggy Leatt and Sandra Leggat, "Healthcare Governance in Transition: From Hospital Boards to System Boards – A National Survey of Chairs of Boards," *Hospital Quarterly*, Winter 1998; 2(2): 28.
[31] Hundert and Crawford, 2002: 63.
[32] Hundert and Crawford, 2002: 63.

actually *owned* by corporations who can be made up of either just the boards themselves and/or board members and non-board members (i.e.: board members in waiting or members of the community who purchase a membership).[33] This type of corporate governance arrangement creates a challenge in defining the relationship between the citizen, the government and the hospital board through clear lines of accountability.

B) Public Participation and Traditional Governance

The complexity of this issue increases when membership to the hospital's corporation remains open (e.g. members of the community can buy corporate memberships or all members of the community are members of the hospital by virtue of residence). In this instance the hospital's board has dual accountability, both to the Ministry of Health and Provincial government for the funds it receives, and to its corporate membership which can potentially be the entire community it serves.[34] At the same time, the public holds the government accountable for the funding, organization, delivery, and, to a large extent, quality of hospital (and other health) services.[35] In the diagram below, the solid black lines indicate the direct lines of accountability, while the dashed line represents indirect or potential lines of accountability.

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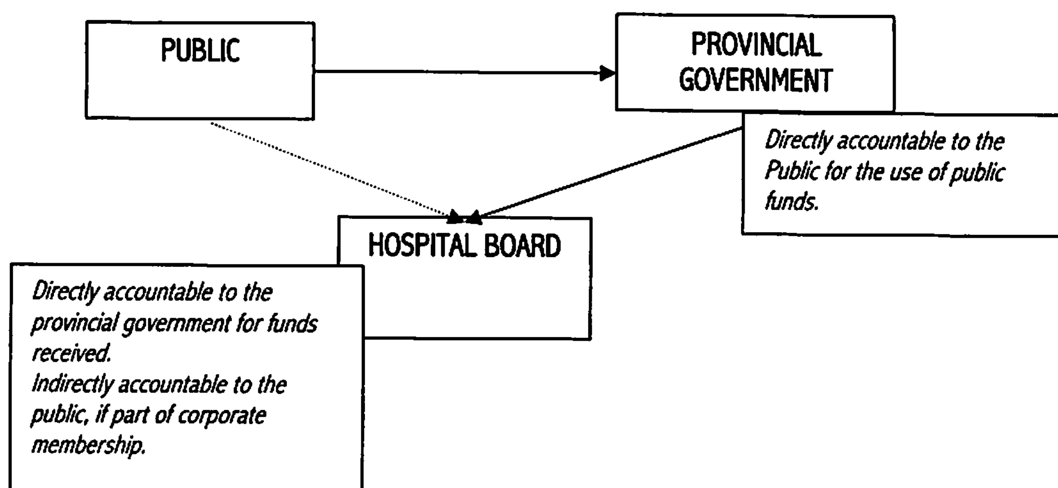
[33] Wayne Taylor, "Facts, Myths and Monsters: Understanding the Principles of Good Governance," *The International Journal of Public Sector Management*, 2000; 13(2/3): 115.
[34] Ontario's *Public Hospitals Act* does not stipulate any requirements for corporate membership. It affords all public hospitals the authority to determine their own membership arrangements in their governing bylaws. As an illustration, Figure 3, is a chart outlining the requirements for corporate membership for all of the hospitals in the Thames Valley Hospital Planning Partnership.
[35] Hundert and Crawford, 2001: 63.



In this traditional governance arrangement, the public is involved in a hospital's health care delivery decision-making process indirectly through its relationship with the provincial government as a taxpayer, and possibly as a member of the hospital's corporation. The province holds considerable power over the hospital's decision-making apparatus as a result of its position as the sole funding body in the healthcare system. In this respect, the provincial government does not impose its views on service delivery directly on the hospital's board; however, the Ministry of Health is able to indirectly impose policies aimed at ensuring fiscal conservancy. Means such as the provision of one-time funding for individual hospitals and other financial constraints are all aimed at encouraging managerial initiatives such as restricting admission criteria, reducing the average length of stay and reducing the overall number of hospital beds.[36] The power of the provincial government to direct a hospital's decision-making processes is exercised indirectly by limiting the board's access

[36] Neil Hanlon, "Hospital Restructuring in smaller urban Ontario settings: Unwritten rules and uncertain relations," *Canadian Geographer*, 2001; 45(2): 253. [Hereinafter referred to as: Hanlon, 2001].

to scarce financial resources. Conversely, public participation is engaged at the local or community level only by a select few who are elected or appointed directors of the hospital's board.

C) Calls for Reform

At the very moment in 1984 when the federal government passed the *Canada Health Act,* guaranteeing accessible, equitable health care for all Canadians, the provincial governments began to struggle to find ways to contain costs and ensure efficiency. In order to respond to the introduction of a national medical insurance program, provincial governments and hospital administrators implemented policies and programs aimed at achieving shorter inpatient stays and promoting the greater use of outpatient and ambulatory modes of care. Provincial governments, through funding methods shifted the emphasis from institutional (hospital-based) care to population health, prescreening and diagnostic techniques and limiting the need for extended pharmaceuticals, as methods to encourage shorter hospital stays and contain costs. As a result, there has been an overall reduction in the rates of utilization of hospital-based services and recovery time.[37] As Neil Hanlon finds with regard to the evolution of the restructuring process in the province:

> In Ontario, the provincial Ministry of Health has been preoccupied with containing the growth in hospital funding since the publicly funded health insurance program was expanded from its original focus on hospital insurance to

[37] Hanlon, 2001: 254.

> provide full coverage of medical services in the late 1960s. The principle means by which the Ministry seeks to impose fiscal conservancy among the self-governed public hospitals has been the use of block funding constraints to encourage managerial initiatives such as more restrictive admission criteria, shorter hospital stays and a greater reliance on ambulatory care and day surgery.[38]

Given the government's necessity to reduce spending and control the costs of the health care system, planning for, management of and accountability within the health care system has been reconsidered.[39] The extensive research of Jeremiah Hurley, Jonathan Lomas and Vandna Bhatia at McMaster University, in Hamilton Ontario, finds that even though fiscal realities and financial considerations, are important rationales driving the provincial reforms to better manage health care resources, there are also other recommendations and observations that have had a significant impact on the development of health service reform. Some of these include:

- The need to manage medical discretion - determining medical need is not as objective as was once imagined and the delivery of medical services responds to a host of factors beyond patient need (payment method, practice organization, physician preferences etc.).
- The inadequacy of existing efforts to decrease reliance on predominantly institutional health care, particularly for a growing elderly population.
- The need to reduce the significant proportion of medical care that is either ineffective or inappropriate for the situation in which it is being provided.
- The lack of accountability for use of inefficient mixes of resources
- The failure to plan for health care in an expanded framework of the broader determinants of health.[40]

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[38] Hanlon, 2001: 255.
[39] Hurley, Lomas and Bhatia, 1997: 493.
[40] Hurley, Lomas and Bhatia, 1997: 493.

Throughout the 1990s, the need for system-wide reform and restructuring continued to be a primary focus for the province as a result of the major rounds of cuts to the federal transfer payments, by the federal Liberal Party, under Finance Minister Paul Martin. As a reflection of the need to contain costs better manage the health care resources in the country all of the provinces in Canada embarked on a health services restructuring plan. The restructuring plans, and the rationale to defend them, can be summarized within the following six themes:

> Better management will not only *contain costs*, but also will produce and deliver services with *improved efficiency* in ways more *flexible* and *responsive* to community needs. Reformation will improve *integration and coordination* of complementary and substitutive services, ensuring a full continuum of care available, whenever possible, in a community setting and evaluated according to *health outcomes.* Finally, there is to be a significant increase in *community participation* in planning decisions for health care.[41]

There is little doubt that the impact of the 1990s on the social service systems in Canada will be one of vast change. As a nation, Canada continues to experience the effects and reverberations of that change on its public service organizations.

D) Health Services Restructuring in Ontario: 1990s a Legacy of Change

In the late 1990s, the Ontario provincial government took what was one of the most unique and dramatic approaches to hospital and eventually health system reform. In 1994, the newly elected Progressive Conservative party in the

[41] Hurley, Lomas and Bhatia, 1997: 494.

province of Ontario, introduced legislation, through the *Omnibus Bill*, which completely changed the strategic direction of all hospitals in the province. By creating the Health Services Restructuring Commission (HSRC), in March 1996, the Ontario government believed it could expedite hospital restructuring in the province and advise the Minister of Health on revamping and recreating other aspects of Ontario's health services system.[42] Essentially, the HSRC was designed to bring a 'systemic' approach to the management, administration and governance of the continuum of health care services throughout the province. From primary care emergency rooms to continuing care nursing home settings, the Ministry believed they would be able to achieve cost containment and improved efficiency by reducing duplication among all constituent organizations within the system. In March 1996, two weeks after the Chair of the Commission, Duncan Sinclair, and the HSRC Commissioners were appointed, a Ministry advisor to the Commission explained the role and mandate of the HSRC:

> First a key caveat: the HSRC is not simply a hospital restructuring commission. The chair, and I, suspect most of the Commissioners anticipate a wider-angle view of the health system. One cannot consider hospitals in isolation from community and social services, including home care programs; one cannot consider acute care hospitals in isolation from chronic and rehabilitative institutions.[43]

The appointment of HSRC presents the clearest example of a shift from institutionalized, organization-controlled, health care delivery to the creation of

[42] Ontario, Health Services Restructuring Commission, Looking Back, Looking Forward, Seven Points for Action (Toronto: The Commission, March 2000). www.hsrc.gov.on.ca/HSRC.pdf.
[43] Insight Information Inc., *Health Care Services: Implementing the New Agenda*. (Toronto: Insight Information, 1996), 19.

an integrated health care delivery system. Regardless of the strategic direction of the Board of Directors or individual hospital administrators as a result of the HSRC process, all hospitals became part of the "continuum of health care". The result - a major overhaul of the healthcare system from governance and decision-making through all clinical applications and service delivery.

The first phase of the HSRC process began with the Provincial Government declaring that the HSRC was to eliminate $1.3 billion from the base funding for all hospitals in the province. Between 1996 and 1999, the HSRC declared that 33 public hospital sites would no longer be used as hospitals (although some would remain open converted into ambulatory care centres or nursing homes). Additionally, the HSRC recommended that six psychiatric hospital sites and six private hospital sites be closed. In April 1999, the Commission presented a summary report to the Minster of Health on the "hospital restructuring" first phase of the HSRC process. The report states that the following five key outcomes of hospital restructuring are to be in place by 2003:

1. Urban hospitals will be consolidated into larger organizations on fewer sites.
2. Rural and northern hospitals will be reorganized into networks.
3. Patients now occupying hospital acute care beds should have access to home care, long-term care, rehabilitation, mental health and sub-acute care.
4. Capacity for specialized services such as MRI's, hip and knee replacements, cardiac surgery and radiation therapy for cancer patients, will be improved.

5. Hospital buildings will be renewed and many new community based facilities created.[44]

The second half of the HSRC mandate focuses on the question of health service integration and resource sharing, in other words the development of integrated service delivery systems. The HSRC's recommendations to the Minister promote greater horizontal and clinical integration. The recommendations also encourage smaller community hospitals and other community health care delivery organizations, located in relatively close proximity to each other, to plan and coordinate services together and for urban hospitals to centralize services at macro-hospital sites and rationalize service delivery between all urban locations. The government remains committed to the provision of high quality health care services close to home for all Ontario's communities.

The position of the Ministry of Health was, and continues to be, that the system of community self-governance over hospital management promotes a 'silo' culture among individual hospitals. The lack of coordination and cooperation between hospitals is considered, by the Ministry, as the major barrier to the achievement of the integrated delivery system concept, which guided the HSRC process, and is believed to be the policy direction that will increase efficiency and promote cost containment throughout the system.[45]

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[44] Lorraine Luski, *Hospital Restructuring in Ontario*, (Toronto: Legislative Research Services) 2000: 4. [Hereinafter referred to as: Luski, 2000].
[45] Hanlon, 2001: 256.

E) Centralization – Decentralization – Effects on Public Participation

Even though the effects of the HSRC process in the province of Ontario have been dramatic, the Progressive Conservatives did not attempt to completely alter the publicly funded system of health care in the province.[46] The provincial government in Ontario, as opposed to the other provincial governments that were introducing health service reform at the same time, actually sought to centralize decision-making authority and power. While authors such as Dr. David Grazter and other observers of the system, believe this dramatic action is a reflection of the government's commitment to neo-liberalism, market-driven reform and a step towards privatization; in actuality, the government took steps to increase state control over the system. Recognizing the public commitment to a publicly funded health care system, the government chose to centralize health care decision-making in order to control spending, while at the same time guarantee access core services and quality patient care.[47] This centralization of fiscal policy and expenditures, it can be argued, actually contradicts many of the Harris government's other fiscal policies, which are aimed towards decentralization and privatization. The government chose to create the HSRC as an arms-length organization because of the political implications created by choosing to close public hospitals. Even though there were "public consultation" sessions and hearings, there was virtually no role for public dialogue or input into the decision-making process.

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[46] Toba Bryant, "A critical examination of the hospital restructuring process in Ontario, Canada," *Health Policy*, 2003; 64: 202. [Hereinafter referred to as Bryant, 2003]
[47] Bryant, 2003: 203.

And, as Toba Bryant argues, this increased state control actually, "occurred at the expense of the democratic process."[48] Although the government remains committed to its policies to control state spending, achieve economies of scales and reduce the deficit in a high cost budget area, it has not attempted to fundamentally change the ideological foundation of the country, that being the provision of a publicly funded health care system.

For self-governing hospital boards, and their communities, the impact of the HSRC process has been unparalleled. The public discovered that regardless of their needs or wants for their local health care organizations, the government has both the power and the political will to impose its own policies and agenda. Public participation in health care decision-making, since the HSRC was established in 1996, has been almost completely marginalized. As Neil Hanlon notes, "the restructuring imperatives imposed on communities throughout Ontario, pose a serious threat to the self-governing status of hospitals and, with it, the sense of local control over hospital decision-making."[49] Although the government did not attempt to completely change the general policy to provide a publicly funded health care system in Ontario, they did completely alter the relationship between the governing of the system and the general public. Unlike many other cases of provincial restructuring initiatives, the Government of Ontario insisted that the provision of high quality health care service was the primary rationale behind the restructurings, and therefore, the HSRC process did

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[48] Bryant, 2003: 203.
[49] Hanlon, 2001: 256

not include a reconsideration or re-conceptualization for the role of the citizen in the health systems decision-making processes.

V. REGIONALIZATION – THE UNIVERSAL MODEL?

"Regionalization is here for the duration. Governments have achieved a significant degree of consolidation in governance at the regional level, and there has been horizontal integration in institutional care."

- ***Owen Adams***
  Director, Research Directorate for the Canadian Medical Association
  - *Health Policy Forum, Roundtable, Spring 2001.*

One of the primary reasons Ontario's experience with health care restructuring is so unique is a result of the provincial government's choice not to institute an "explicitly" regional governance structure. Underlying the reform initiatives that propose regionalization or regional models is the fundamental belief that a regional system can deliver health care in a more efficient and effective fashion. Throughout the 1990s, all nine of the other provinces and one northern territory in Canada moved toward some form of regionalized health care governance structure. As David Naylor notes; however, "Ontario, the largest province in Canada (population 11.8 million), is a conspicuous exception".[50] The Canadian experiences with regionalization have, in some cases, been derived from many international models, most notably the Oregon rationalization project and the complete system reformation in New Zealand both of which will be explored further in this section.

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[50] David Naylor, "Health Care in Canada: Incrementalism Under Fiscal Duress," *Health Affairs*, May/June, 1999; 18(3): 12. [Hereinafter referred to as: Naylor, 1999].

A) Defending Regionalization

In a comprehensive overview of the Canadian experiences with regionalization, John Church and Paul Barker offer the following definition:

> Regionalization generally means an organizational arrangement involving the criterion of an intermediary administrative and governance structure to carry out functions or exercise authority previously assigned to either central or local structures. Accordingly, regionalization may entail the shifting of responsibility for public health from a series of local boards to a regional agency, or a general devolution of power from a central governing agency to regional boards.[51]

There has been a considerable amount of discussion about the primary rationale for the creation and implementation of regional health authorities throughout the world. Generally, the rationale can be discussed within the context of two primary categories: functional and political.

Functionally, regionalization is defended by advocates of the structural arrangement on the basis that it improves the integration of healthcare services and service delivery across the continuum of care.[52] Essentially, this argument hinges on the belief that regional planning will create coordinated service delivery in so far as health care authorities are able to better identify and eliminate areas where the duplication of services and administration exists within the region thereby containing costs and increasing efficiency. By moving planning and prioritizing to a regional level, governments and administrators are

[51] John Church and Paul Barker, "Regionalization of Health Services in Canada: A Critical Perspective," *International Journal of Health Services,"* 1998; 28(3): 468. [Hereinafter referred to as: Church and Barker, 1998]
[52] Naylor, 1999: 13.

better able to effectively utilize the scarce resources available. For example, integrated, regional service delivery reduces the need to offer obstetrical services in every community hospital. Due to the fact that pediatricians, obstetricians, specialized nursing staff are in high demand and difficult to recruit; obstetrical units can be located in one or two hospitals in a given region; thereby, eliminating competition between hospital sites. Combined with this concept is a vast body of research that better understands the determinants of a population's health (i.e. infection control and preventative medicine). This information suggests a need for a broader conceptualization of how best to address complex health issues. Essentially, healthcare has evolved from the traditional patient-doctor relationship to a much more interdisciplinary approach all aimed at improving patient care. As Steven Lewis suggests, "intersectoral and multi-disciplinary collaboration and cooperation are essential requirements in order to produce healthier populations."[53] To this end; therefore, there is little doubt or even debate, that regionalization, from a planning perspective, is the governance arrangement that is best able to facilitate the maximum and most effective use of scarce resources.

On the other hand, the political rationale used to defend the move toward regionalization vis-à-vis the creation of regional health authorities has become the subject of challenge and debate. Although the federal government has maintained a role in the provision of healthcare as per the *Canada Health Act,*

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[53] Lewis, Steven. Regionalization and Devolution: Transforming Health, Reshaping Politics? HEALNet, Occasional Paper No. 2. Saskatoon: October, 1997: 1. [Hereinafter referred to as: Lewis, 1997]

accountability for the provision of health care continues to rest with the provincial governments as a result of their role as the primary funding body. By maintaining control over organizational budgets and the dispersion of funds to health care delivery institutions, the provincial government is held accountable for the provision of healthcare services. Despite the fact that local hospital boards and other health service organizations are accountable, to the provincial government, for the provision of those services, accountability has never rested directly with the point of service.[54] In order to address this major challenge with respect to direct and indirect lines of accountability, it is suggested that public and citizen engagement in decentralized health system decision-making structures enhance and restore the balance of accountability. The government, sitting in a remote capital somewhere in the province is no longer accountable for the provision of service; rather, the regional communities, including the citizens who are free to engage in the decision-making, are now directly accountable to the citizenry. As a result of this direct linkage to the community, the regional body is able to make more effective decisions by coordinating and creating a health system that is responsive to local needs rather than provincial priorities.

[54] Lewis,1997: 1.

B) International Experiences with the Regional Models

i) Oregon

It is difficult to determine the degree to which the rationing experiments in Oregon had an impact on the Canadian reform efforts. On one hand there is no tangible evidence of a direct causal relationship; on the other hand, the rhetoric and rationale that supports the creation of community-based regional governance structures is remarkably similar to that utilized during the Oregon process.[55] Even though the American health care system is extraordinarily different and often difficult to compare to the Canadian counterpart, the approach taken by this state provides one of the first steps towards the consideration of a regional framework that incorporates a new role and responsibility for public participation. In the late 1980s throughout the United States, many politicians and state legislatures realized that the public's expectation for the provision of government-funded social services was on an inevitable collision course with the resources available.[56] The most common response to this situation by the majority of states in the US was the reduction and restriction of the eligibility criteria for the Medicaid program, or socially provided medical services. Oregon; however, decided to strike out on its own as it's Government, "decided that exercising fiscal restraint by penalizing the most disadvantaged persons in society was neither politically nor morally viable."[57]

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[55] Candace Johnson Redden. "Rationing Care in the Community: Engaging citizens in health care decision making," *Journal of Health Politics, Policy and Law,* December, 1999; 24(6): 1368. [Hereinafter referred to as: Redden, 1999].

[56] Harvey Kievit, et. al., "Prioritization of Health Care Services: A Progress Report by the Oregon Health Services Commission," *Archives of Internal Medicine.* 1998; 151(5): 913.

[57] Redden, 1999: 1371.

In response, the state established the Oregon Health Decisions (OHD) plan, which oversaw the creation of a Health Service Commission (HSC). The plan called for the creation of a list of prioritized health care services that would be provided by the state. From 1989 through 1993, the HSC worked at drafting a comprehensive and viable list of health services ranked from most to least important. Citizen engagement and participation became an indispensable part of the rationalization and prioritization process. Nineteen community meetings helped established the criteria and set the priorities for rationalization, ultimately resulting in a statewide debate on social values and health care priorities.[58] As Candace Redden notes in her analysis of the Oregon experiment:

> Oregon legislators recognized that determining which services to fund and which citizens to include in the plan were value laden decisions that needed to be made through a process of community-guided, clinical judgment, in order that a significant degree of legitimacy could be accorded to the rationing exercise.[59]

The primary reason the Oregon experiment is so important for this analysis, especially for the purposes of comparison, is because this process signals the first step toward the integration of a deliberative method of public participation in decision-making. The Oregon process is also the first process involving the public in questions and issues about the rationalization of health care services. It signals an important shift in the role and responsibility of the citizen from a passive consumer to an active citizen engaged in a process of rationalization

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[58] Redden, 1999: 1372.
[59] Redden, 1999: 1373.

designed to create more effective health system decisions and ultimately improve the health care services for the entire community.

ii) New Zealand

New Zealand is an important and viable comparator to the Canadian health care system because of the many similarities in its approach to the delivery of health care services. Similar to Canada, governance issues have been a central theme in the many restructuring movements throughout the New Zealand healthcare system. Until the late 1980s, the organization and financing of the health care system resembled the system currently in place in Ontario. Public health was funded and run by central governments and the district offices of the health bureaucracy; hospitals and their associated community services were centrally funded, but run by locally elected boards; and the primary health care, or general practice physicians, were run by private practitioners partly funded by government on a fee-for-service basis.[60]

As a first attempt at reformation, in 1989, the national government in New Zealand created fourteen geographically defined Area Health Boards whose primary responsibility was for planning, funding and coordinating secondary services such as hospitals and public health units. The function and role of the Health Boards were remarkably similar to the District Health Councils as they currently exist in Ontario. By the early 1990s; however, the system of health

[60] Pauline Barnett, et. al., "On a Hiding to Nothing? Assessing the corporate governance of a hospital and health services in New Zealand 1993-1998," *International Journal of Health Planning and Management*, 2001; 16: 142. [Hereinafter referred to as: Barnett, 2001].

care in New Zealand began to face major challenges. The system became plagued with long waiting lists for surgeries and other minor procedures; fragmented funding from both public and private sources created a lack of responsiveness to need and there seemed to be an overall lack of fairness and equity, questionable levels and quality of services, major inequities in access to primary health care services and general practitioners, uncontrolled growth in expenditures, lack of accountability for costs and quality and almost no community participation in governance structures.[61]

As part of a major restructuring of the health care economy and social service provision in New Zealand in 1992, the fourteen regional health boards were replaced by four regional health authorities.[62] Hospitals and public health units were restructured as crown enterprises, to be managed and considered as semi-private corporations. The Regional Health Authorities became primarily responsible for the purchasing of primary and secondary services from the newly created crown enterprise health corporations with the underlying understanding that the services purchased would "meet the health needs of the community."[63] The health needs of the community were determined in a process very similar to the one adopted by the Oregon Health Decisions plan. Essentially, a Core Services Commission was established with the mandate to identify the health care priorities of the nation and the four regional communities. Community

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[61] John Marriott and Ann Mable, Opportunities and Potential: A Review of International Literature on Primary Health Care Reform and Models (Ottawa: Health Canada, August 2000): 38. [Hereinafter referred to as Marriott and Mable, 2000].
[62] David Hadorn and Andrew Holmes, "The New Zealand Priority Criteria Project. Part 1: Overview," *British Medical Journal*, January 1997; 314: 132.
[63] Bernett, 2001: 143.

meetings within each of the regions were held in order to produce a "government defined cores services list," which became the purchasing and supply guidelines for the Regional Health Authorities.[64] Essentially, the Regional Authorities were accountable to the Ministry of Health to ensure all core services were provided to the community by purchasing them from the health service corporations. For hospitals, this type of restructuring signified a shift from a bureaucratic/democratic model of governance to a corporate model of management and administration. Community participation and citizen involvement is engaged by the Regional Health Authorities as process through which the "needs of the community" is evaluated and the core services list is reviewed and revised. Citizens are actively engaged in the discourse about what services will be offered and when and how the healthcare priorities will be funded or allocated.

Even though there are differences between the approach to restructuring and citizen engagement taken in Oregon and the one adopted in New Zealand, both examples are significant in the context of Ontario. The Oregon and New Zealand restructuring processes emphasize rationalization and prioritization of health care services as the primary rationale for the creation of regional health authorities. Conversely, in Ontario, and indeed the rest of Canada, the emphasis and rationale driving the restructuring process has tended to rest more with resource management and a shift in service provision.

[64] Marriott and Mable, 2000: 40.

C) Regionalization in Canada

Generally, regionalization in Canada has been an effort aimed at controlling expenditures and integrating services, not at reengaging with the public on matters of social policy or priority setting, as is the case in both the Oregon and New Zealand examples. Like the examples; however, the Canadian experience with regionalization has been an attempt to decentralize control for the provision of services from the provincial ministries, to a regional authority. John Church and Paul Barker find that even though all of the provinces have attempted to restructure their systems in light of their own specific needs, there are some common characteristics. These are as follows:

1. The creation of regional governance and management bodies composed of either elected officials or a combination of appointed and elected. This has most often entailed a consolidation of existing board management structures (e.g. 127 hospital boards, 133 nursing home boards, 45 home care boards have become part of the consolidated regional structures in Saskatchewan).

2. Some form of global budgeting has been transferred to the regional level. In general, all Ministries provide regional health authorities with a set amount of money to be used in a manner consistent with broad standards.

3. A shift in emphasis from institutional based care to community-based settings for service delivery. The belief is that regional structures are better suited to effect such a systemic shift because the RHA system allows decision-makers the ability to move resources from one program to another without having to deal with traditional organizational barriers.

4. Underlying desire to evaluate the types of outcomes produced by the health services system. (e.g. the development of evidence-based funding formulas).

5. A clear devolution of responsibility from provincial health ministries to regional authorities resulting in a downsizing and restructuring of the provincial ministry.[65]

Given the international trend towards greater community engagement and participation, it is interesting to note that the creation of a community dialogue and citizen engagement in service rationalization are not cited as one of the common characteristics. Throughout the literature, in fact, many authors do not emphasize the advancement of a deliberative, democratic dialogue concerning rationalization or prioritization of services in Canada. Rather, the Canadian experiences with regionalization have essentially extended the idea of representative governance, from traditional hospital boards and other institutional boards to the regional health authority. Interestingly; however, many provincial governments often defend their province's move toward regionalization based on the belief that this type of governance system creates a more participatory and accountable decision-making process

Of course, as mentioned previously, Ontario's experience with restructuring is an exception to the rest of the country. It is important to note that in fact Ontario has had a long history with regionalization and does in fact poses a quasi-regional structure. In 1973, Ontario created a District Health Council (DHC) structure. Geographic boundaries for the DHCs are based on traditional referral patterns around teaching hospitals and health sciences centres. The composition of the DHC's is prescribed by the provincial

[65] Church and Barker, 1998: 471-472

government – forty percent consumer or citizen, forty percent service provider and twenty percent locally elected municipal representative. The scope and authority of the DHCs is limited in so far as they are primarily advisory bodies, whose objectives are to conduct planning and priority setting.[66]

As Julia Abelson notes; "while DHCs are not the only mechanism through which extensive public consultation occurs in Ontario, they certainly have one of the most explicit mandates for incorporating public input into health-systems decision-making."[67] The DHC's, while advisory have actually facilitated the greater involvement of the public in the integration and collaboration of services. Ontario's District Health Councils have been integral organizations in the introduction and consideration of health service rationalization. While the HSRC process does not directly address or restructure the role or function of the District Health Councils, it does continue to emphasize the need for "continued leadership in planning."[68] Essentially, it has become the role and responsibility of the District Health Councils to engage all organizations in discussions on rationalization and integration. The fundamental problem and drawback with this system; however, is of course the DHC's limited ability to exercise authority over health-systems' decision-making processes.

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[66] John Warren, How Many Roads? Regionalization and Decentralization in Health Care. Queens-CMA Conference. Dorland, John ed. (Kingston: Queen's University Press, 1996) 128.
[67] Abelson, Julia et al., 2001: 91.
[68] Health Services Restructuring Commission, Rural and Northern Framework: Advice and Recommendations to the Honourable Elizabeth Witmer, Minister of Health and Long-Term Care, (Toronto, February 2000): 16.

VI. DISCUSSION – Public Participation: Re-Engaging the Dialogue

Although not explicit, the HSRC process in the province of Ontario has actually implemented and created a regionalized health care decision-making process. This action is of course distinct from the rest of the country in so far as all of the other provinces have chosen to implement an explicit governance structure. Aside from the impact on the traditional models and structures for public participation in the province, Ontario has actually seen a strengthening and consolidation of decision-making authority at a regional level. By emphasizing the need for service integration and collaboration between all health care delivery organizations, the province actually is encouraging, and, in some respects, creating a regional governance process, without actually prescribing an explicit governance structure. Whereas other models, such as those in the majority of the Canadian provinces and the New Zealand reform, attempt to reconcile the need for efficiency and cost containment with the demand for greater accountability, through the institution of a regional structure, Ontario maintains traditional lines of accountability. Power and authority; however, have been deferred from local boards to regional partnerships and networks. This is not to say that local boards no longer exist, they most certainly do, and the real question is what is their current function? In a personal interview, Mike Mazza, Chief Executive Officer of the Middlesex Hospital Alliance[69] notes, "since 1996, the power of hospital boards to make decisions

[69] The Middlesex Hospital Alliance is an Alliance agreement between Strathroy Middlesex General Hospital and Four Counties Health Services. It is also a member of the Thames Valley Hospital Planning

about service delivery has become severely limited. As a result of the costs of technology and the scarcity of human resources, health care services and their delivery must be coordinated and integrated with our regional partners. All of this is negotiated at the Thames Valley Hospital Planning Partnership."[70] In the case of Ontario; therefore, regionalization is being driven by the need for improved rationalization of the acute care hospital sector, improved integration of long-term and community-based care and the need for cost containment and improved efficiency.[71] Ontario has essentially chosen to allow the organizational structures (i.e.: hospitals and public health units) to rationalize healthcare services and their delivery on their own.

Ontario has not chosen, like the Oregon and New Zealand examples to incorporate public participation and forms of citizen engagement into its regional decision-making structures as a means to assist with prioritization and rationalization. This is not to say that Ontario has completely disregarded a role for public participation in health systems decision-making. In June 2002, the Ministry of Health and Long-Term Care released: A Public Dialogue on Health Care, which outlines and discusses the results of a province-wide opinion poll. Despite the fact that in a Pollara study conducted in 1998, 96% of those persons polled agreed, "substantial repairs, if not a complete rebuilding, are necessary to

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Partnership, which is a partnership between all 8 hospitals and the District Health Council in the Thames Valley.

[70] Personal Interview, Mike Mazza, CEO, Middlesex Hospital Alliance. June 27, 2003.

[71] Naylor, 1999: 19.

maintain the health system's quality."[72] An Angus Reid poll conducted in 1999 also found that the majority of Canadians believe the health care system is in decline.[73] The Public Dialogue Report, commissioned by the Ministry of Health in Ontario, found that almost 72% of the respondents rated the system as "good".[74] The question for consideration here is not about the validity of the survey; rather it is about the appropriateness and usefulness of this type of "public dialogue" as a methodology by which to actively engage the citizenry. What does a poll that finds that 72% of the respondents agree that the healthcare system is good tell decision makers about the value of one healthcare service over another? Essentially, is the government in a position to make a more effective decision, which reflects the values of Ontario as a society by engaging the public in this way?

A) Why Not Ontario?

If regional governance allows for greater efficiency gains through service integration and reductions in duplication, and public participation creates more effective decision-making; why then, has Ontario not moved more directly toward this type of system? One the reasons is the definite lack of political willingness by a majority of the political parties in Ontario. In a personal interview with the former Chair of the Board of Directors for the London Health

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[72] Dr. David Gratzer, Code Blue: Reviving Canada's Health Care System, (Toronto: ECW Press, 1999): 20.
[73] *Ibid:* 20.
[74] The Strategic Counsel. A Public Dialogue On Health Care: A Report to The Ministry of Health and Long-Term Care, (Toronto: January, 2002), www.gov.moh.on.ca: 12.

Sciences Centre[75], Geoff Davies states, "the bureaucrats in the Ministry [of Health and Long-Term Care] realize that the creation of regional planning structures will be necessary in order to sustain the continuum of care from primary to secondary to tertiary to academic centres. For some reason, there is a definite lack of political will by the elected MPP's to completely adopt Regional Health Authorities."[76] Prior to the 1999 provincial election, the Ontario Hospital Association sent a questionnaire to the leaders of the three political parties. In response to the question: *What is your position on the applicability of regional health authorities to the health care delivery system in Ontario?*

Ontario Liberal Leader, Dalton McGuinty replied:

> "We believe in the role of government in the setting and enforcement of health care standards. But we do not believe in a government that micro-manages the delivery of health care. We support local input in health care delivery and decision-making. We will not move in the direction of a regional health model, which removes local governance."[77]

Ontario Conservative leader (and Premier), Mike Harris replied:

> "A Mike Harris government will not view regional health authorities as a key health care priority. However, we will continue to work more closely with rural hospitals within the context of the Rural and Northern Health Framework to encourage greater integration of appropriate health services while at the same time respecting local autonomy. A Mike Harris government will also continue to fully support the integration of health services as part of the

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[75] Geoff Davies was Chairman of the Board from 1999 – 2001 the period when the Health Services Restructuring Commission was restructuring the London Health Sciences Centre. He has since been appointed as the provincially appointed Supervisor for the Toronto East General Hospital and Four Counties Health Services (appointed directly by Cabinet and the Premier of Ontario). In July 2003 he assumed the position of Chief Executive Officer for ICS courier systems.

[76] Personal Interview, Geoff Davies, July 2, 2003

[77] Ontario Hospital Association, Regional Health Authorities in Canada: Lessons for Ontario, A Discussion Paper, (Toronto: January 2002): 45. [Hereinafter referred to as: OHA, 2002].

> hospital restructuring process for hospitals implementing the directions of the HSRC."[78]

Remarkably, the stance of the leaders of the two largest political parties in the province on the implementation of regional health authorities is fairly similar.[79] But despite the criticism leveled against the HSRC process and the impending provincial election, there has been very little discussion of regionalization in the province in recent months. Combined with the lack of political will is the lack of interest or inclination on behalf of the public in Ontario. In 1995, Julia Abelson and her colleagues initiated a survey, which suggests that the residents of Ontario are not that inclined to participate in regional health care decision-making arrangements and would actually rather the responsibility be deferred to elected officials.[80]

Fundamentally, the creation of regional health authorities requires provincial governments, and provincial Ministry's of Health devolve a considerable amount of power and authority over one of the largest areas of public expenditures in the country. Despite the fact that many of the provinces have created some form of regional governance structure, many of them are still wary about relinquishing full powers to the local authorities. The structures in New Brunswick and Newfoundland and, to a lesser extent, Quebec are particularly constrained in scope and probably better characterized as

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[78] OHA, 2002: 45.
[79] Howard Hampton, Leader of the New Democratic Party of Ontario, did not respond to the survey.
[80] Abelson, J. et al. "Does the Community want Devolved Authority? Results of Deliberative Polling in Ontario," *Canadian Medical Association Journal*, 1995; 153(4): 420. I believe the results from this study are now fairly questionable as it was conducted prior to the HSRC process. In corresponding with Dr. Abelson, I was informed that she and her colleagues are in the process of preparing an updated survey and study.

"deconcentrated". Those in Alberta, Saskatchewan and Prince Edward Island have the greatest authority and none of the regional authorities, in any province, have any fund-raising capabilities.[81] And, in an interview with Paul Collins, President and CEO of the St. Thomas-Elgin General Hospital, he notes, "there is no way the [Ontario] government would give up that kind of control over individual hospitals. They always want to be at the table."[82]

Not surprisingly, the health care system in Canada, as in many other countries has been dominated by the political will demand of its physician groups. As more and more physicians choose to leave the country demand for these scarce human resources elevate the level of power and control they have over the system. While the Canadian Medical Association (CMA) has taken a more academic or advisory role on the regionalization issue, the Ontario Medical Association has made public statements strongly opposed to the implementation of regional health authorities. Currently, the *Public Hospital's Act* stipulates that physicians must be represented on the Board of Directors, normally the Chief of Staff, the President of the Medical Staff Association and up to two other representatives. As a result of their medical expertise, physicians are often in a position of control and influence.[83] In most of the provinces, medical service providers, including physicians, have been excluded from the regional authorities out of fear that the role of the authority will be compromised if the providers and

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[81] Jonthan Lomas, John Woods and Gerry Veenstra, "Devolving Authority for Health Care in Canada's Provinces: 1. An Introduction to the Issues," *Canadian Medical Association Journal*, 1997; 156(3): 371. [Hereinafter referred to as: Lomas, Woods and Veenstra, 1997].
[82] Personal Interview, Paul Collins, President and CEO, St. Thomas-Elgin General Hospital, July 4, 2003.
[83] Lewis, 1997: 9.

their interests retain direct decision-making power. This has caused many physician groups to feel excluded from the new channels of advice and influence.[84] Physicians have historically been the "gatekeepers" to the wider system of health care. In an integrated health care delivery system, that role and the control that comes with it is greatly challenged. In a statement by the Ontario Medical Association in regard to regionalization and the HSRC process issued in 1997, they note:

> The OMA strongly supports a model whereby patients continue to be directly linked to a primary care physician as their point of first contact with the health care system and coordinator of patient care...additionally, the OHA rejects the underlying tone of *regionalization* throughout the HSRC documentation.[85]

Historically, the OMA has held a tremendous influence over the health policy direction of the province. Considering their opinion on regionalization, and even integrated service delivery systems is so negative, it is difficult to believe the government will pursue this policy explicitly despite the position of the physicians.

B) Decentralizing Power – Centralizing Community

Despite the potential benefits a regional governance structure that incorporates effective means for public participation presents there are still a number of issues and challenges. One of the most interesting and conceptually complex issues within the entire regionalization discussion is the concurrent

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[84] Lomas, Woods and Veenstra, 1997: 375.
[85] Ontario Medical Association. "Comments on the HSRC vision of Ontario's health services system," www.oma.org, 1997-01-03.

process of centralization and decentralization that must take place. In referring back to Dalton McGuinty's argument against regionalization, one can assume that he believes regionalization results in a loss of "local control" over health-systems decision-making. This seems counterintuitive as the entire theoretical discussion advocates for the involvement of the "community" in health care decision-making structures. Just as deliberative forms of democracy require a reconceptualization of *participation*, this type of regionalization, especially in Canada, requires a reconceptualization of *community*. While regionalization adds a new layer of authority, it also must wipe away a huge local governance apparatus. In many communities (particularily rural areas) power is actually devolved up as traditional community boundaries are dissolved.[86]

What is so interesting about this argument is the counter-point now being debated by many academics and researchers who are considering the issue of urban citizenship and the decline of communities. Raisa Deber, a professor of health policy at the University of Toronto, questions why health care planners and legislators continue to talk about "community" in a 1970s sense, when the information revolution and advances in individual mobility have almost rendered the term meaningless for the majority of Canadians.[87] Understanding "regions" as opposed to "communities" may be a reality for many Canadians in the years ahead; however, as Ontario's experiences with municipal amalgamations have

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[86] Lewis, 2.

[87] Charlotte Gray, "CMA – cosponsored conference raises many questions about future of regionalized health care," *Canadian Medical Association Journal*, 1995; 153(5): 1060.

shown, there still seems to be something deep and fundamental about communities and community identity.

A secondary issue that arises from this need to redefine communities within a regional structure, is a challenge faced by all of the deliberative democratic theorists; that being who represents the "community"? In a paper entitled Community Representatives: Representing the "Community"? by Rachel Jewkes and Anne Murcotte, they find the meaning of community is subject to extensive debate and social analysis. It is even more difficult, they note to operationalize the term as a means by which to create more effective public policy.[88] In a further analysis on the effects of context on health-systems decision making, Julia Abelson finds that while approaches to involving the public in local health care decision making processes have tended to treat participation and publics uniformly, in fact, participation and the constitution of the public is greatly affected by differing socio-economic, cultural, institutional and political contexts from within the decisions are made.[89] There are countless studies and theoretical debates that have gone on at length in an attempt to sort out this extremely complicated issue. Some of the provinces have chosen to elect some of their Regional Health Authority representatives. In Saskatchewan, the province to experiment most with regionally elected representatives, found that in 1997, only 10% of the province voted.[90] This low turnout certainly causes

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[88] Rachel Jewkes and Anne Murcott, "Community Representatives: Representing the "Community"?" *Social Science and Medicine*, 1998; 46(7): 846. [Hereinafter referred to as: Jewkes, 1998].
[89] Abelson, 2001: 779
[90] Church and Barker, 1998: 472.

one to question the validity of "democratic representation" in this case. It is not the goal of this discussion to offer solutions; however, it is important to note, that this challenge exists and that a means of reconciliation to this issue must be identified as regional governing models continue to be introduced and restructured.

A third and final issue for consideration, again something common to the broader and deeper ideological debate, is the question of obtaining public participation or the public willingness to deliberate. In 1978, the World Health Organization, through the Alma Alta Declaration, identified community participation as being so important it is considered a basic "right" of all citizens. Accordingly, all citizens should be able to participate in decisions about their health care services and it is a corresponding duty of all citizens to take the opportunity to exercise that right.[91] If deliberative methods are to succeed they require buy-in from the community. It is also important that government and society work collectively to build an infrastructure to facilitate civic deliberation within communities and public institutions.[92] Deliberation to this extent is a difficult concept. It requires a fundamental re-conceptualization of the traditional means of democracy. Often critics cite the fact that deliberative processes are difficult and timely to execute and; therefore, should not be used to inform difficult decisions or crisis issues. Does it not seem; however, that these are precisely the opportunities where deliberative methods should be most

[91] Jewkes, 1998: 846.
[92] Abelson et. al, 2003: 248.

fully utilized, where questions of social values and value-based choices must be made?[93]

VII. CONCLUSION

Can Ontario reconcile the goals of public participation, which is to say the creation of more effective decisions, with the goals of cost containment and efficiency by instituting regional health authorities? The answer to the question has to be yes. Even though the politicians in the province of Ontario are unwilling to move towards complete regionalization, regional planning structures that enable service alignment and integration have been found to be the most viable method through which the use of scarce resources can be maximized.

Ontario, while committed to the creation of an integrated service delivery system of health care, has chosen to completely alter the relationship between the citizenry and the local governing apparatus, especially in relation to health care decision-making structures. As the population ages, financial and human resources will become scarcer. We, as a society, will not be able to "have it all", nor will we be able to provide it all. It is exactly then, when decisions about what our healthcare priorities will be and what healthcare services we will provide, when citizens should be engaged through an active process of rationalization and dialogue. These issues and the ones that are currently being debated in the healthcare sector are issues about the core values of society.

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[93] Abelson et. al: 247.

These are the precise dialogues that should be engaged by the citizenry through an active role in the decision-making and prioritizing of Canadian healthcare expenditure. The Canadian health service system and its administrative structures have an opportunity to recreate and redefine the relationship between individual citizens and government. In balancing the inherent tension between efficiency and effectiveness, systems that incorporate both the values of public participation and the principles of integration and coordination have an opportunity to continue in the development and evolution of democratic societies.

FIGURE #1

Traditional Public Participation

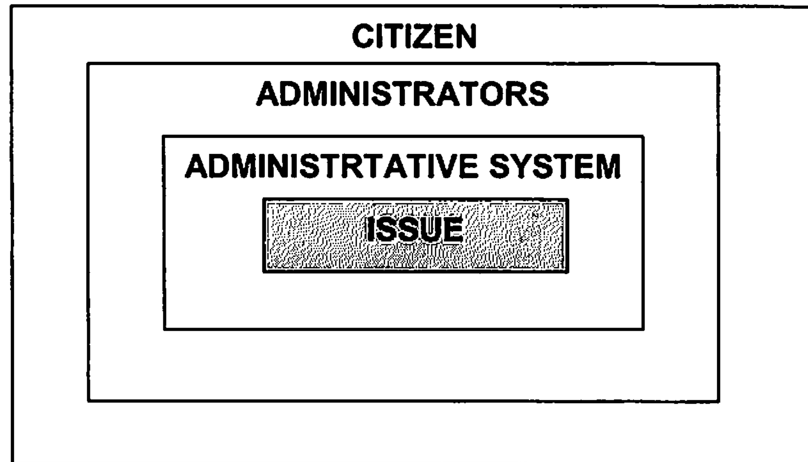
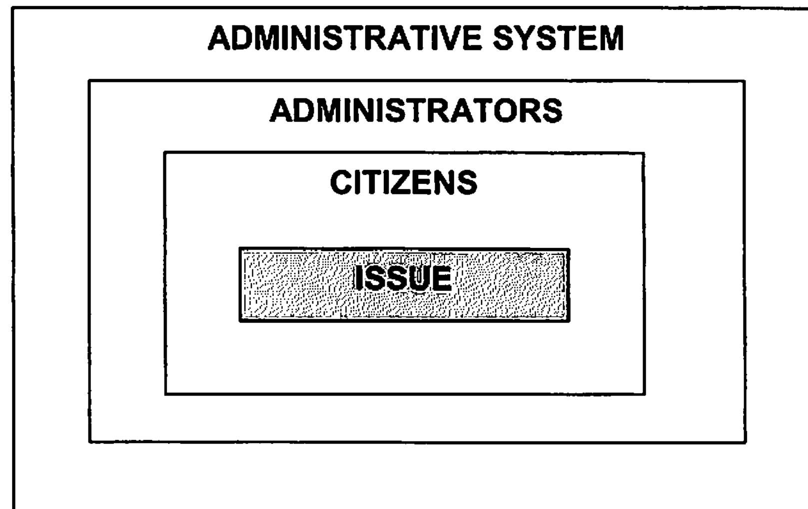


FIGURE #2

Authentic Public Participation



From:

King, Cheryl Simrell, Kathryn Feltey and Bridget O'Neill Susel. "The Question of Participation: Toward Authentic Participation in Public Administration," *Public Administration Review.* 1998; 58(4): 322, 323.

FIGURE #3

Comparison Chart – Corporate Memberships
Thames Valley Hospitals

Name of Organization	Life Memberships	Annual Memberships	Rights of Members
Tillsonburg Memorial Hospital	Yes - $100	Yes - $5	Vote at AGM
Woodstock General Hospital – WGH Board of Trustees	Yes - $1000	Yes - $10	Vote at AGM Quarterly Newsletter
Alexandra Hospital – Ingersoll	Somewhat – available for those who donated $500 over course of lifetime – only have 3 or 4 who are former CEO's and who live outside of the Ingersoll catchment area	Yes – FREE All residents of catchment area who are over 18 are members of the corporation's membership	Vote at AGM but must prove they live inside catchment area.
St. Thomas – Elgin General Hospital	Yes Firms/ Organizations - $5000 Individuals - $1000 over 5 years	Yes Firms/Organizations - $1000 Individuals - $25	Vote at AGM
London Health Sciences Centre	Upon merger all memberships to both UH and South Street were grandfathered as LHSC members (approx. 100). There will be no new corporate members at LHSC – membership is limited to Board members while they are serving out their terms.	NO – due to governance restructuring all individual memberships have been frozen (formerly annual memberships were $20)	Vote at AGM
St. Joseph's Health Centre	NO	NO– in order to be a member of the St. Joseph's hospital all individuals must be a member of the St. Joseph's / London Diocese Society	
Strathroy-Middlesex General Hospital	NO	NO	
Four Counties Health Services	All FCHS corporate memberships have been suspended due to appointment of provincially appointed Supervisor Previously Life Members – donors of $100 over lifetime	Annual was - $20	Vote at AGM

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