

**THE REGIONALIZATION OF HEALTH CARE IN
BRITISH COLUMBIA:
DOES 'CLOSER TO HOME' REALLY MATTER?**
by

Paul Kevin Weaver
B.A. Simon Fraser University, 2003

RESEARCH PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS

In the
Department of
Political Science

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SIMON FRASER UNIVERSITY

Spring 2006

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APPROVAL

Name: Paul Weaver
Degree: Master of Arts, Department of Political Science
Title of Project: The Regionalization of Health Care In British Columbia: Does “Closer to Home” Really Matter?
Examining Committee:

Chair:

Dr. Tsuyoshi Kawasaki, Associate Professor
Department of Political Science

Dr. Daniel Cohn, Assistant Professor
Senior Supervisor
Department of Political Science

Dr. Michael Howlett, Professor
Supervisor
Department of Political Science

Dr. Olena Hankivsky, Associate Professor
Internal Examiner
Department of Political Science

Date Defended/Approved:

April 11th, 2006



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ABSTRACT

Driven in large part by the increasing costs of health care delivery, the majority of Canadian provinces initiated a series of commissions or task forces to investigate the status of their health care systems in the last two decades. Emerging from these discussions, regionalization was thought to be the best remedy to address the respective financial and organizational challenges of the various provinces. Yet, despite widespread adoption by almost every jurisdiction, very little is known about the impact of this phenomenon on provincial health systems. This project evaluates whether regionalization in British Columbia's health system was able to overcome a number of challenges with this method of health care reform identified by Church and Barker. Taken from their important appraisal of regionalization across Canada, these authors identified several problems with regional health systems that must be surmounted if provincial health systems are to change the way in which they operate rather than merely be reorganized. Based on this investigation, the project argues that although regionalization has somewhat improved health care operation in British Columbia, the health system still suffered from a number of difficulties during the 1990's that prevent regionalization from being described as an effective reform.

DEDICATION

For Sandra Louise.

ACKNOWLEDGEMENTS

Both directly and indirectly, a great number of people have helped me complete this degree. Specifically, however, I would especially like to thank my very good friend Sandra Louise. Without her continued grace, patience and understanding, I would not be the man I am today.

I must also acknowledge the significant contributions Dr. Stephen Phillips and Mary Goldie from Langara College and Dr. Michael Howlett of Simon Fraser University have made to my education. It has only been through their insight, wisdom and continued words of encouragement, that I have been able to accomplish things I never imagined possible. I am in their debt.

Finally, I would also extend my gratitude to my supervisor Dr. Daniel Cohn and my friend Andrea Balogh. During my time at Simon Fraser University, both have willingly devoted their valuable time and energy to ensure I stayed the course. They will always be a continued source of motivation and inspiration.

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INTRODUCTION: MOVING BEYOND PROVINCIAL HEALTH CARE

Faced with a common set of problems, countries across the developed world embarked on a wave of health care reform in the 1990's. Confronting a rise in public expectations, the restraint or retrenchment of public and corporate spending, increasing costs of care and the proliferation of new and expensive medical technologies, a range of proposals were brought forward to deal with these problems. Though considerable progress has been made to alleviate their attendant tensions in recent years, significant challenges remain.

Canadian health care has not been immune to these waves of reform. A review of the literature indicates that the provision of health care is taking place in a significantly different context than it has in years past. Driven in large part by the restraint of government expenditures and increasing costs of health care delivery, the majority of Canadian provinces initiated a series of commissions or task forces to investigate the status of their health care systems over the last two decades. Many of the reports identified a number of

similar problems,¹ recognizing the need to improve the operation of provincial health systems. Common to these discussions, was the recommendation of regionalization, which was thought to be the best remedy to address the respective organizational and financial challenges of the various provinces. Yet, despite wide adoption by almost every jurisdiction during the 1990's, surprisingly little is known about the impact of this phenomenon on provincial health systems. This project assesses regionalization in the province of British Columbia.

Originating from experiences in Europe (Greener and Powell, 2003), regionalization generally refers to a way to structure how provincial health services are managed and provided (CCARH, 2003). First implemented in Canada in the early 1990's, the move towards regional health systems has involved establishing intermediary governance structures (also known as Regional Health Authorities or Boards), which carry out significant aspects of the decision-making and planning responsibilities formerly assigned to central ministries of health or local hospital boards. Quickly spreading to every province except Ontario during the 1990's, regionalization has significantly

¹ Several frequent themes emerged from these provincial inquiries; (1) a need for containing escalating costs; (2) improvements to the efficiency and effectiveness of the system; (3) enhancing accountability and responsiveness; (4) a perceived necessity for facilitating citizen participation; (5) improved health outcomes; and (6) better co-ordination and integration of health services. Douglas E. Angus, "A Great Canadian Prescription: Take Two Commissions and Call me in the Morning," in Restricting Canada's Health Service System: How Do We Get There From Here? Eds. Raisa B. Deber and Gail G. Thompson (Toronto: University of Toronto Press, 1992): 49-62; Jonathan Lomas, "Devolved Authorities in Canada: The New Site of Health System Conflict," in How Many Roads...? Queen's CMA Conference on Regionalisation and Decentralization in Health Care, John L. Dorland and S. Mathiwin Davis eds. (Kingston ONT: Queen's University School of Policy Studies, 1996): 34-35; Albert F. Wesson, "The Comparative Study of Health Care Reform," Health Care Systems in Transition: An International Perspective, Francis D. Powell and Albert F. Wesson (London: Sage, 1999): 3-24.

reconfigured many provincial health care systems through the formation of geographically defined areas of health (Lomas, Woods and Veenstra, 1997; Church and Barker, 1998; Naylor, 1999).

A close reading of the Canadian literature suggests that regionalization not only reorganizes the structure but also decentralizes the management and planning of provincial health care in an effort to improve how the system works (Church and Barker, 1998; Davidson, 1999). Because the regional boards are closer to the communities they serve, regionalization, in theory, is thought to accomplish this objective through a better distribution of financial resources (Hurley, Lomas and Bhatia, 1994; Lomas, 1996). In practice, however, some authors argue that there are still a number of problems in the effect regionalization has had on provincial health systems (Church and Barker, 1999; Haley, 1999; Lomas, 2001; Kouri, 2002).

In keeping with this view, the project argues that although regionalization began as a bold new policy agenda for health care in British Columbia, questions remain about whether this reform has made a difference in how the health system works. Instead, the currently available data indicates that health care resources have simply been shifted from one sector to another without any meaningful improvement to how the system actually functions.

Layout of the project

This research project assesses the impact of regionalization in British Columbia during the 1990's. In doing so, the project is divided into three parts and five sections. The first and introductory section generally describes the project, its data, methodology and purpose. The next section, which begins part one, explores the Canadian literature on regionalization and puts forward a definition of regional health systems. Next, the health spending patterns in British Columbia are examined in section three. The purpose of this part of the project is to determine whether regionalization has in fact led to a restructuring the health care system in British Columbia. That investigation sets the stage for assessing the impact that restructuring has had on the province's health system.

The fourth section or third part of the project then discusses the criteria that will be used to evaluate British Columbia's health system since regionalization has been in effect. This part of the project examines the challenges Church and Barker identify with regional health systems in great detail. Each difficulty is addressed sequentially, concluding that although there has been some progress in attending to these difficulties, there are still a number of challenges regionalization has not addressed. The fifth and final section summarizes the research findings. In addition, some research that might follow from this project is also discussed.

Data and methodology

According to Vedung (1997), evaluation is concerned with the later stages of the public policy cycle, with administration, outputs and outcomes. The aim of evaluation is to produce after-the-fact conclusions as to how a policy or program has performed in regard to one of the above three stages of policy cycle. Evaluation rests on a presumed belief in rationality. If one did not believe that deliberate steps could be taken to alter performance then evaluation itself would make little sense.

This project undertakes a two-part evaluation of British Columbia's health care system. The time period under investigation is the decade of the 1990's, but particular attention is paid to the move toward a regional health system as outlined in *New Directions for a Healthy British Columbia: Meeting the Challenge, Action for a Healthy Society* (hereafter referred to as *New Directions*) in 1993 and its formal revision in 1997. Throughout the study, health expenditures will refer to the public and private costs associated with provincial health care services in the province of British Columbia for which the primary objective is to improve or prevent the deterioration of health status (CIHI, 2004).

Data on British Columbia's health expenditures are from provincial information reported to the Canadian Institute for Health Information (CIHI). Taken from the 2004 National Health Expenditure Database, the data provides some of the most recent and comprehensive public information

available on Canada's provincial health systems. The amount allocated to British Columbia's provincial health system from before regionalization went into effect until the end of the decade serve as bookends for the analysis of part one. Towards that end, total spending (including both public and private sources of payment), along with the annual changes in expenditures allocated to different parts of the health care system are used as aggregate indicators² of the change in funding allocated to provincial health care in the 1990's. These spending categories are then compared to the changes occurring in annual expenditures as a proportion of the health budget so as to assess whether the regional reforms achieved their objective of taking health out of institutional settings (i.e. hospitals), and bringing health closer to home (all other spending³). Part one seeks to determine whether regionalization has in fact, restructured health care in British Columbia.

Part two evaluates the performance of British Columbia's health system since regionalization has been in effect to the end of the 1990's. The criterion for this appraisal originates from the problems discussed by Church and Barker (1999). Taken from their assessment of regionalization across Canada, Church and Barker identify five problems associated with regional health systems that must be surmounted if provincial health systems are to

² In the National Health Expenditure Database, the Canadian Institute for Health Information (CIHI) lists a much more comprehensive breakdown of health spending categories and indicators of those expenditures, such as; hospitals, other institutions, physicians, other professionals, drugs, capital costs, public health and administration and all other spending.

³ All other spending includes 'other institutions' (i.e. residential care facilities), 'other health professionals', 'public health and administration' and 'other spending health spending' (i.e. home care). "Other health spending" is a CIHI distinction. Note: since fee for service reimbursement and the amount of prescriptions are for the most part beyond provincial control, this list does not include costs for drugs or physicians

change the way in which they operate rather than merely reorganized. These problems are listed below:

- (1) The integration and coordination of the administration and delivery of services;
- (2) Consolidating the funding mechanisms;
- (3) The information needed to develop indicators and measurements for meaningful outcome evaluations;
- (4) The accountability of citizen participation mechanisms; and
- (5) The potential to become dominated by local, professional or even special interest.

The great strength in Church and Barker's research lies in its methodological flexibility. For example, it can not only keep the assessment of regionalization in a macro perspective, but can also be applied in the micro sense to measure the impact of regionalization in the British Columbia case. Church and Barker's framework suffers from a key weakness, however, in that research shows that problem five may be very difficult to resolve. Towards that end, Tomblin (1999) has argued that the main problem facing Canadian health care is not only the dominance of physicians but also the power of the bio-medical model of care. These are two problems that will not be addressed in this project because it may be unrealistic to expect any single reform to address issue five, which will likely require an entire systemic change to the way health care is funded and delivered to be resolved. Based on this understanding, the project will only address the resolution of the first four issues.

While more is said about these issues below, for now it is enough to note that the solution to these problems is considered a prerequisite for effective regional reform. Assessing whether these difficulties have been resolved will provide a useful way to evaluate what if any effect regionalization has had on the health system in British Columbia.

Measuring the success or failure in dealing with these problems occurs through content analysis of public records. This content analysis involved the systematic collection of mentions of problems with regionalization, each of which authenticates whether there were challenges with the health system after regionalization took effect. As an easily replicable methodology, content analysis is not only very flexible but also reliable as well. While other methods could be chosen to investigate the regionalization of British Columbian health care during the 1990s, given time and resource constraints, this method is also very simple to use.

This method includes looking at provincial government publications such as reports from the provincial Auditor General and Annual Reports from the Ministry of Health, along with daily editions of the three biggest newspapers in the province for the time period under investigation. These searches look for mention of problems with regionalization from when the reforms were formally articulated in 1993 to the end of the decade. Results from the newspaper searches are expressed in frequency tables to document their occurrence while the Auditor General and annual reports from the Ministry of Health are described in more detail. Through this process, the

project seeks to determine whether British Columbia has been able to overcome the difficulties identified by Church and Barker and actually change the way in which the health system operates, rather than just the way it was funded and structured.

The two-part evaluation serves as a proximate way to assess whether British Columbia's health system has changed because of regionalization. All source material was obtained from publicly available information. Data analysis and presentation takes place where appropriate.

To summarize, a close reading of the Canadian regionalization literature suggests that a reorganized and decentralized health system will improve provincial health system performance (Hurley, 1994; Church and Barker, 1998; Davidson, 1999). In theory, because the regional boards are closer to the actual communities they serve regionalization is thought to improve how provincial health systems operate (Lomas, 1996; Hurley, 2004). In practice, however, there are still a number of doubts whether this reform has produced any meaningful advances (Lomas, 2001; Benoit, Carroll and Millar, 2002; Kouri, 2002).

The purpose of this project is to address the research question of whether the health care system in British Columbia has changed because of adopting a regionalized health care model. Towards that end, it investigates whether moving health care 'closer to home' has occurred in more than just the rhetorical sense. If indeed this change has taken place, then the problems noted by Church and Barker will have been resolved.

PART ONE: REGIONALIZATION IN CANADA

In Canada, much of the literature that explores the effect of regionalization on provincial health systems reflects an eclectic assortment of empirical, expository and methodological limitations. For example, many works are general investigations, overly thick on description, lacking a clear theoretical focus or empirical data. Similarly, other research emphasizes narrow, hard to quantify aspects of the reform process. Still further research, has focused on either the merits or disadvantages of regionalization as a whole. A close reading of this research indicates some dispute regarding just how effective regionalization is and in what ways, it actually improves provincial health care systems. The following section discusses the Canadian scholarship on regionalization. Based on this examination, the research suggests the British Columbia case is much different than other Canadian regional initiatives and that there are a number of challenges regional health systems have not addressed.

In one of the first comprehensive examinations in Canada, Hurley, Lomas and Bhatia (1994) looked at regionalization as an instance of reorganizing the existing provincial health care governance structure. Their investigation of six provinces argued that the fiscal reality of the 1990's required a formal restructuring of the institutions responsible for provincial health care decision-making. Despite some diversity in approach, powers, scope of authority, and stage of implementation, their research found three

broad models of organization. For them, regional initiatives generally adhered to models characterized by: (1) devolution; (2) deconcentration; or (3) decentralization, each of which suggested that the provinces were headed towards more decentralized health governance structures. Based on their findings, the authors argued that regionalizing provincial health systems, particularly with respect to the planning and management functions, would ensure better management of provincial health care resources because these decisions were closer to the actual people that used the services. Since the move towards adopting a regional health system would include elections for the membership of the newly created RHA's, the authors specifically identified British Columbia's as one of the provinces likely to have the most potential for improving not only citizen participation, but also the accountability of that province's health care decision makers.

Soon after implementation, regionalization experienced a great deal of recognition as a major source of change in Canadian health care. Together with the Canadian Medical Association, Queen's University organized a conference to discuss the phenomenon in 1995. Published as How Many Roads? Regionalization and Decentralization in Health Care, the conference proceedings addressed a broad range of topics related to regional health systems in both Canada and abroad.

For some of the conference participants, regional bodies were assumed to remedy many of the challenges facing Canada's provincial health care systems. For example, regionalization was thought to contend with the need

for better accountability for the spending of scarce health care resources by increasing public participation and community involvement in health care policy-making. In addition, regional health systems were also considered as a way to increase system wide efficiency by containing costs, thus alleviating problems with system flexibility through improved responsiveness, integration and coordination. And finally, regionalization also sought to expand on the traditional notion of health by moving it away from crisis oriented or institutional based care. For the most part, however, regionalization was considered as a means towards another end and was looked at as a way to obtain system wide cost savings. Given the complexity of health care and a number of potential unknowns about how the reforms would play out, however, it was established that although an important issue, regionalization was in need of ongoing monitoring and evaluation.

In 1997, Lomas collaborated with Woods and Veenstra, examining regionalization in five Canadian provinces. Unlike previous studies, their research studied regional health systems as an explicit occurrence of devolution and its implications to provincial health care policy communities. Administering a survey to the members of regional boards, the authors examined several aspects of regionalization, publishing their results in a series of articles for the Canadian Medical Association Journal. Lomas, Woods and Veenstra found substantial variability in the scope of services administered by the different boards. Further analysis also discovered some inter-provincial convergence in accountability mechanisms, degree of authority and methods

of funding. Yet, although they recognized the potential to alleviate some problems with the decision making and organizational structure of provincial health care systems, the authors were unconvinced that regional health authorities would improve provincial health care. In the end, they followed suit with those before them, recommending continued evaluation.

Intrigued by the initial findings, a number of other Canadian studies have focused on specific dimensions of the regional authorities. Higgins (1999) for example, investigated the community involvement mechanisms in British Columbia. Echoing sentiments expressed in the final report of the British Columbia's Royal Commission on Health Care and Costs—herein after referred to as the Seaton Commission—Higgins found the boards lacked adequate representation from British Columbia's diverse public health stakeholders such as the province's many First Nations communities. Among other things, she argued there was a need to be much more representative in designing public methods of participation to ensure broad based community involvement.

Building on the general study carried out by Higgins, Abelson et al commented on the implication of having the public participate in the planning and management of provincial health services (Abelson et al, 2002). Of particular importance to the health care governance processes, their research focused on the accountability and legitimacy of decisions coming from these mechanisms in both Ontario and Quebec (Abelson et al, 2002). Although their findings did acknowledge some optimism about the future of such

bodies, especially as mechanisms to increase public input and improve citizen efficacy, just as earlier studies had before them, they found reason to doubt the legitimacy of the process. In the end, Abelson et al concluded that the interaction of decision makers and community stakeholders with vested interests created the impression of pre-determined outcomes. The interactions, which were thought to politicize the decision-making process, also reduced the credibility of board decisions.

Similarly, Vakil (1997) also examined the public participation elements of regionalization in British Columbia, but only as part of a larger agenda of government and public sector reform. Viewed from a new public management perspective, her study looked at the regional reforms as an ambitious form of alternative service delivery. Given this point of view, implementation of the regional reforms was an attempt to not only improve the effectiveness of health services, but also a way to increase the accountability of provincial decision makers and obtain efficiencies throughout the health system. Although her work was conducted too early in the implementation process to account for any substantive changes Vakil did suggest that the probability for achieving some of these objectives was significant. This was especially true with respect to the potential for achieving greater efficiencies through the amalgamation of existing agencies and health services under the authority of new regional and community based authorities. She was less than optimistic about the prospect of achieving improved accountability and effectiveness; however, referring to problems

with entrenched political and administrative interests, her study recommended caution and a need for continued scrutiny.

In 1999, Church and Barker wrote an important review of regionalization. Their research identified a number of explicit challenges facing this approach to health care reform. While other authors articulated some pragmatic optimism about regionalization's potential, which may allow provincial health systems to operate in a more efficient, fair and responsive manner, Church and Barker argued just the opposite. In particular, the authors pointed out that simply too many obstacles stood in the way of regionalized health systems achieving their promised objectives.

Specifically, Church and Barker identified five difficulties with regionalization. These problems are identified as follows:

- (1) The integration and coordination of the administration and delivery of services;
- (2) Consolidating the funding mechanisms;
- (3) The information needed to develop indicators and measurements for meaningful outcome evaluations;
- (4) The accountability of citizen participation mechanisms; and
- (5) The potential to become dominated by local, professional or even special interests.

Based on their assessment, the authors concluded that provincial governments should reconsider the implementation of regional health care arrangements. That is, in spite of the potential benefits, both past experience and research conducted in other jurisdictions (Church and Barker, 1999), provided the

authors with little indication that regionalization would improve provincial health care. This project seeks to determine whether this indeed turned out to be the case in British Columbia.

Regionalization Defined

As a term, regionalization has often eluded definition. In this regard, it has been used as a multi faceted label to describe how many provincial governments across Canada sought to reform health care in the 1990's. For example, British Columbia has described regionalization as the development of a regional (decentralized) health system designed to manage and delivery provincial health services (British Columbia, 1991). Because the British Columbia definition is overly vague, this project will use the explanation put forward by the 2002 Senate Standing Committee on Social Affairs, Science and Technology Report on the Health of Canadians.⁴ It has introduced one of the better definitions of the regional health care model and the local government agencies created to give effect to this model:

⁴ In 2002, the Senate Standing Committee on Social Affairs, Science and Technology, chaired by the Honourable Michael J.L. Kirby issued a six-volume report as part of the national debate on health care reform. The report, commonly referred to as the Kirby Commission after its chair, was titled The Health of Canadians: The Federal Role. See reference list for full citation.

[Regional health authorities are entities] with responsibility for health care administration within a defined geographic region within a province or territory. They have appointed or elected boards of governance and are responsible for funding and delivering community and institutional health services within their regions.

Given such complexity, regionalization can be primarily thought of as an organizational device to reform the delivery and management of provincial health services to improve operation.

In summary, the literature review has drawn attention to several important points about regionalization. For instance, the regional reforms are not all structural. Rather, they involve a number of administrative, cultural and organizational shifts as well. Research to date indicates that regional health systems attempt to reorient the focus of provincial health care by placing an emphasis on both the process and outcomes of how health care systems operate, instead of just how they are organized (Benoit, Carroll and Millar, 2002; Frankish, 2002). In addition, the literature review also highlights the fact that regionalizing provincial health systems also changes the accountability for health care planning and decision-making processes (Fraser, 1995; Lomas, 1996; Davidson, 1999). This aspect of the process underlines the importance of prioritizing and managing the allocation of scarce health care resources and is a particularly problematic aspect of regionalization. Finally, while only the most important have been discussed here, the sheer abundance of Canadian literature also points out that regional health systems are no longer theoretical or political exercises, but are instead complex realities, which suffer from a number of key failings.

An assessment of this phenomenon is not a simple task, however; for government policy is often vague and ambiguous (Stone, 2002). In addition, evaluating policy success or failure is an extremely malleable proposition and ample empirical evidence suggests such judgments are in many cases partially linked to economic, social and political factors, all of which make it virtually impossible to isolate their impact (Bovens and Thart, 1996). The following sections seek to determine whether regionalization's goal of moving health care 'closer to home,' has improved health care operation in British Columbia.

Regionalization in British Columbia

Similar to many other provinces, British Columbia first took steps to regionalize its health system in the early 1990's. First articulated in the 1991 *Seaton Commission*, the report suggested that a great deal of progress could be made in the allocating scarce health care resources to improve disparities in both access and service delivery by adopting a regional health system. In response to the Commission's findings, the Ministry of Health announced the government would adopt this policy in June 1992. In so doing, the province ushered in a tumultuous decade of policy change for health care in British Columbia.

Outlined in a strategic plan called *New Directions*, implementation of a regional health system sought to accomplish five objectives:

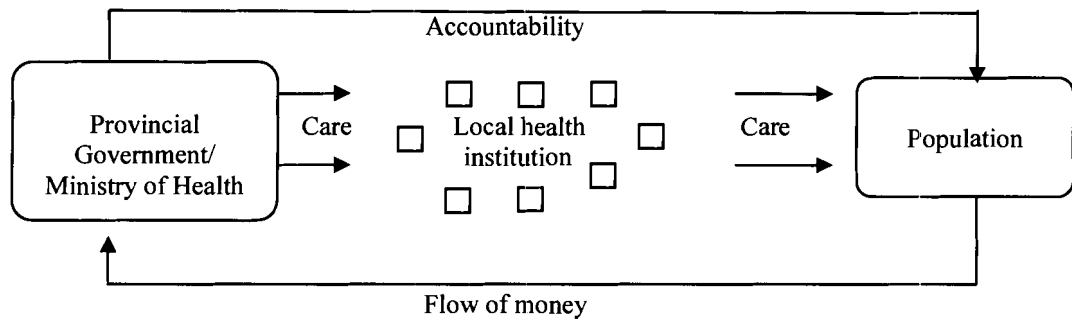
- (1) Take health care out of institutional settings and move it closer to home:
- (2) Broaden the notion of health:
- (3) Promote more effective organizational management:
- (4) Enhance public participation and responsibility in the health care services decision making process: and
- (5) Respect health care providers.

Acting on the Seaton Commission's recommendations as outlined in *New Directions*, the adoption of regionalization is believed to have significantly restructured health care and the health care system in British Columbia. For example, in the years following adoption of the Commission's recommendations, the province aggressively moved to create a series of regional structures, which it thought would improve health system performance by making health care more responsive to local needs (Davidson, 1999). Based on this belief, the province planned to shift much of the authority for planning and management of health services, away from the provincial Ministry of Health, to regional and community oriented bodies. Yet, this belief has been shown to have number of serious difficulties.

Prior to establishing a regional health system, most provinces simply delegated authority to a multitude of different agencies, local hospital boards and provider associations, which, in return for funding, undertook the delivery

of health services to the general population. This model has been criticized as a fragmented system of care and accountability (Lewis, 1997; British Columbia, 1998) regionalization was therefore seen as a way to correct this fragmentation by creating a series of meso level agencies that would take over the administration and delivery of health services in explicit territorial jurisdictions within the province. Figure one on the following page demonstrates this relationship as a feedback loop.

Figure 1:
Flow of Care and Accountability Pre-Regionalization

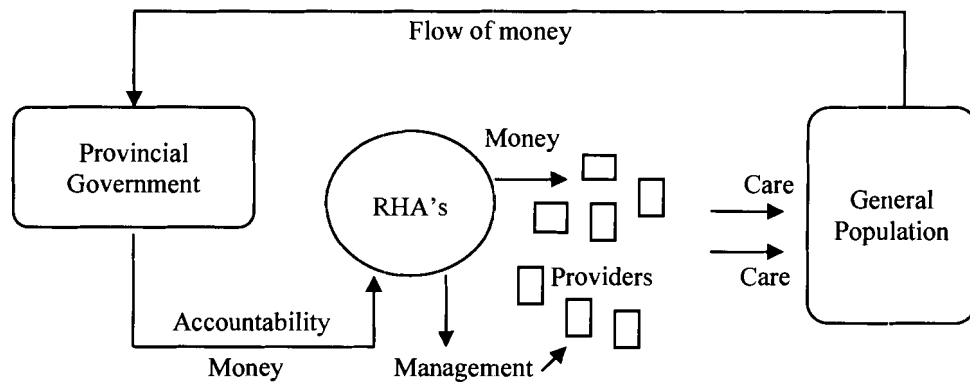


Vakil (1997) has discussed the complexity of this objective. In her examination of regionalization in British Columbia, she indicates that there were approximately 700 different agencies (hospitals, long term care agencies, mental health facilities etc.), each of which delivered health services across the province before regionalization took effect. In Vancouver alone for instance, she found that some 196 different health care organizations worked autonomous from one another. This autonomy often meant that community clinics and local hospitals would service similar, overlapping areas, which, in

many cases duplicated resource allocation and service delivery. As an important plank of the regional plan, the different agencies, administrative services and provider groups that delivered patient services in specific geographic areas were to be consolidated under a single governing umbrella. In doing so, it was thought integration would create administrative economies of scale, which would improve service delivery, avoid redundancy and ultimately, save the province money.

Generally considered a community oriented and democratic empowerment approach to health care reform, (Higgins, 1997; Davidson, 1999; Abelson, 2002; CCARH, 2003), devolving decision-making power to the regional structures, was in part, premised on the notion that effective policy delivery is difficult to achieve from centralized government departments or ministries (Lewis, 1997). The new structures were intended to carry out the functions and responsibilities previously assigned to central or local bodies through either upwards or downwards movements of responsibility and authority, which altered the feedback loop (See Figure 2 at the top of page 22). In the end, the restructuring not only sought to simplify and better coordinate the administration and management of health services (Church and Barker, 1999; Denis, 2002; Lomas, 2004) in explicit jurisdictions, but also across the whole province.

Figure 2:
The Care and Accountability Feedback Loop of Regionalization



Source: Adapted from Jonathan Lomas, "Devolved Authorities in Canada: The New Site of Health-Care System Conflict," in *How Many Roads? Regionalization and Decentralization in Health Care* (Kingston ONT: Queen's University School of Policy Studies, 1996): Figure 2, p. 30.

Yet, even though the intention was to regionalize the facilities where health service delivery occurs by the change in policy—where the way in which services were provided was altered—the relationship between physicians and the province essentially remained the same (Mitton and Donaldson, 2002). Put differently, while the location of service delivery was supposed to come under regional authority, most provincial physicians are autonomous professionals who for the most part, decide their own schedules, without any direct control over their actions from the regional authorities. All other things being equal, this means there is a serious problem embedded in the regional process in that physicians continue to have near total discretion in their behaviour but the facilities they require to practice medicine and which must cope with the aggregate consequences of their individual choices, are going to be under regional management.

Aside from this embedded contradiction, *New Directions* was also different from regional initiatives in other provinces. In fact, the British Columbia experience could be considered an anomaly. Unlike the double tiers of governance present elsewhere (regional authorities acting within the powers delegated from the provincial health ministry), British Columbia attempted to implement a three tiered regional governance structure with 82 Community Health Councils (CHC's), which were grouped into 20 Regional Health Boards (RHB's), which in turn came under the direction of the provincial health ministry. For these reasons, the regionalization of British Columbia's health system represents an important case study to assess.

Responsible for overseeing delivery in small, mainly rural areas of the province, the CHC's were the smallest entities, intended to be the primary provider of health services and function as a venue for public input to 20 health boards. Somewhat larger in terms of their responsibilities and scope of authority, the Regional Health Boards (RHB's) were to be in charge of the delivery of services not covered by the CHC's in larger urban centres. This responsibility also involved administering operational funding received from the ministry of health to the CHC's (CCARH, 2003; Frankish et al, 2002). According to *New Directions*, the CHC's would report to the RHB's, and the RHB's to the ministry of health, which would retain a significant leadership role in the province's health system.⁵ The target date for the full transfer of

⁵ The Ministry of Health was to retain primary authority and responsibility for health policy and planning, ensuring an appropriate level and standard of health services to all regions, providing funding to the RHBs, monitoring and evaluation, physician payments, Pharmacare

responsibility from the ministry to the 100 governance structures or regional health authorities (RHA) was planned for the summer of 1996.

Once concerns began to emerge about the regionalization process,⁶ *New Directions* was superseded by another change in British Columbia's health policy. In November 1996, *New Directions* was modified with the publication of *Better Teamwork, Better Care*. Significantly directing the focus of regionalization away from the participatory approach initiated in *New Directions* (Davidson, 1999), *Better Teamwork* sought to streamline the regionalization accountability process through amalgamation and appointment, rather than election of RHA members (CCARCH, 2003).

Put simply, the approach of *Better Teamwork* sought to more effectively manage the health system in British Columbia. To accomplish this goal, *Better Teamwork* cast off the community oriented approach set up in *New Directions* reducing the number of RHB's from 20 to 11 and CHC's from 82 to 34. It was also decided that the CHCs (mostly intended to serve the more rural and remote areas of the province) were to work in cooperation with 7 new Community Health Services Societies (CHSSs). The newly established CHSSs would oversee non-hospital services (i.e., Public Health, Adult Mental Health, Community and Continuing Care) within their

and the administration of a few highly specialized health services (i.e. tertiary care, Provincial Officer of Health and the Department of Vital Statistics).

⁶ The Regionalization Assessment Team (RAT)—appointed by Minister of Health and Minister Responsible for Seniors Joy McPhail to evaluate the *New Directions* regionalization process—expressed concerns about the accountability of health decision making processes and the potential of regionalization to maintain cost effective health service delivery levels/practices.

respective regions, which left the responsibility for acute care to the CHCs (Penning, 2002). The transfer of responsibility to the new RHA's was rescheduled to occur April 1, 1997. Yet, with little evaluation (Lomas, Woods and Veenstra, 1997; Benoit, Carroll and Millar, 2000; Leatt, 2000), it is not very clear what impact these changes have had on health care in the province. Because the British Columbia case is much different from the other regional initiatives in other provinces, much can be learned by assessing this unique provincial experience. For example, addressing the reforms in British Columbia will be helpful to other jurisdictions for not only will our experience provide the other provinces an opportunity to better understand British Columbia's multi level approach to regionalization, but also because it presents the opportunity for other jurisdictions to benefit from our health reform experience. In this way, they can either adopt or avoid British Columbia's approach. The next two sections seek to investigate the changes regionalization is thought to have brought about British Columbia's health system.

PART TWO: ASSESSING REGIONALIZATION

In the last couple of decades, the performance of Canada's provincial health care systems has been a prominent concern. Like other major industrial nations over the latter half of the twentieth century, Canada experienced a steady growth of expenditures allocated to finance health care. In the literature, it is regularly argued that the escalating costs have put increasing pressure on provincial governments to sustain and/or improve the performance of their health care systems (Tholl, 1994; Naylor, 1999; British Columbia, 2000; Canada, 2002). A close reading of this literature suggests the spending is an indication of the relative health of the system (Madore, 1994; Blomqvist, 1994; Hurst, 2002; Lazar and St-Hilaire, 2004). This fiscal reality presents a useful starting point to assess the impact of regionalization in British Columbia.

Shown in calendar years and expressed in current dollar amounts, Table 1 on the following page represents the total health spending in British Columbia over the 1990's.

Table 1:
Health Expenditures in British Columbia, 1990 -2002 (Expressed in Millions of Current Dollars)

(A) Year	(B) Total Public	(C) Annual % Change of Public Spending	(D) Total Private ⁷	(E) Annual % Change of Private Spending	(F) Total Public and Private Spending	(G) Annual % Change to Health Budget	(H) Per Capita	(I) % of Prov GDP
1990	5,386.70	13.7	1,986.00	12.0	7,372.60	13.3	2,240.37	9.3
1991	5,967.20	10.8	2,159.50	8.7	8,126.70	10.2	2,409.00	9.9
1992	6,477.90	8.6	2,291.20	6.1	8,769.10	7.9	2,528.24	10.1
1993	6,869.80	6.0	2,427.00	5.9	9,296.80	6	2,606.03	9.9
1994	7,237.50	5.4	2,519.10	3.8	9,756.50	4.9	2,654.34	9.7
1995	7,538.40	4.2	2,560.60	1.6	10,099.00	3.5	2,673.80	9.6
1996	7,688.70	2.0	2,675.50	4.5	10,364.20	2.6	2,675.13	9.5
1997	7,942.60	3.3	2,875.20	7.5	10,817.80	4.4	2,739.69	9.5
1998	8,302.70	4.5	3,084.10	7.3	11,386.70	5.3	2,858.78	9.8
1999	8,978.10	8.1	3,275.50	6.2	12,253.70	7.6	3,054.75	10.1
2000	9,821.30	9.4	3,510.10	7.2	13,331.40	8.8	3,300.51	10.2

Source: Adapted from Table B.1.1, B.1.2 and B.1.3 from the Canadian Institute for Health Information, a, National Health Expenditure Database (Ottawa: CIHI, 2004).

⁷ The CIHI 2004 National Health Expenditure Database does not differentiate between public and private health spending per say. Rather, this is an analytic distinction to keep track of whether the source of finance or payment is from the public or private sector. According to CIHI, public sector expenditures are the health care spending by governments and their agencies. Private sector spending on the other hand, is among other things, an individual out of pocket expenditure for health care goods and services (i.e. private spending on health-related capital construction and equipment; and, health research funded by private sources).

At first glance, the pattern of these expenditure categories would appear to indicate that spending on health in British Columbia presents a long-term trend of rising costs during the 1990's. For example, both the public and private expenditures increased during this period, but so too did the per capita and total health spending. There is more here than meets the eye, however, in that this spending growth has been somewhat erratic. A closer look at health spending as a proportion of provincial gross domestic product (column I), demonstrates that health care costs were indeed controlled during the early part of the 1990's, only to increase during the later half of the decade. Moreover, the difference in the annual percentage change to the public and private spending is also significant (columns C and E). From all accounts, a subtle shift in spending patterns has occurred, which may indicate that much of the resources dedicated to health care in British Columbia have been off loaded elsewhere or are being borne by individual contributions, rather than any new government spending. This observation is important because it hints that the site of the spending might be changing from hospitals to the community, where the coverage of costs by provincial programs is less complete. The data trends mentioned above appear to suggest that financial resources allocated to British Columbia's health system are being shifted away from hospital settings to other parts of the system.⁸ This shift was one of the goals of regionalization.

⁸ Other parts of the system include such categories as public health and administration, other institutions and home care, all of which are captured in 'all other spending.' See footnote 3.

Hypothesis one

The data expressed in Table 1 sheds light on some interesting patterns. In particular, while most of the decade shows an increase in overall health spending, reductions to the annual percentage of public and total spending point to some correlation with the regional reforms. Therefore, the first hypothesis will relate to testing the validity of this assumption.

Hypothesis 1: As set out in *New Directions*, regionalization has led to the restructuring of provincial health care in British Columbia as measured by the health care funding going to institutions such as hospitals and all other spending.

The independent variable for hypothesis one is the policy intervention of regionalization, defined above. The dependent variable for this hypothesis is therefore the change to British Columbia's health spending patterns. A focus on following the money is important because the literature on health system reform suggests that public spending is an indicator of how well health systems operate (Madore, 1994; Blomqvist, 1994; Hurst, 2002). To test the hypothesis, the project will measure the extent to which regionalization has achieved a specific objective. As stated in *New Directions*, a key object of regionalization was to move health care out of institutional settings and move it 'closer to home.' This hypothesis is tested by looking at the annual percentage changes to the health budget spending patterns since regionalization has been in effect and the proportion of the

budget allocated to hospitals and all other spending to determine where the money has gone. If the proportion of the health budget allocated to hospitals since the onset of regionalization has declined or remained the same and levels of expenditures going to other parts of the system has increased, then it is very likely that British Columbia's health system has indeed been restructured.

Testing hypothesis one

With a reasonably clear set of variables, it is possible to measure whether any change has taken place. The project operationalizes the dependent variable for hypothesis one as follows. Annual hospital spending as a proportion of the health budget is expressed in Table 2 on the following page. In addition, the year to year percentage change of spending from the annual provincial health budget going to all other spending categories and total spending are placed side by side to show if health care has moved out of institutional settings (i.e. hospitals) and 'closer to home' (all other spending). These public health expenditure amounts are compared to the annual proportion of the health budget going to physicians and drugs as a constant to measure whether regionalization has altered the provincial health funding patterns in British Columbia. If the comparisons show no significant increase

in the amount flowing to doctors and drugs, but a decrease in expenditures going towards hospitals, it is likely there have been changes in community health expenditures, which was a key goal of regionalization. This comparison is shown in table two on the following page.

Table 2:
Measuring Regionalization in British Columbia

(A) Year	(B) % of Total Health Budget Allocated to Hospital Spending	(C) % of Spending to Physicians and Drugs	(D) % of Total Health Budget Allocated to All Other Health Spending	(E) Total Health Spending*
1990	42.45%	28.32%	29.22%	100%
1991	41.84%	28.63%	29.53%	100%
1992	41.58%	27.18%	31.24%	100%
1993	40.93%	27.43%	31.64%	100%
1994	40.24%	27.49%	32.27%	100%
1995	39.35%	27.57%	33.08%	100%
1996	39.19%	27.52%	33.30%	100%
1997	39.44%	27.47%	33.09%	100%
1998	39.95%	27.65%	32.41%	100%
1999	39.00%	27.40%	33.61%	100%
2000	37.75%	27.52%	34.73%	100%

Source: Adapted from Table B.4.1, D.4.10.1, D.4, Canadian Institute for Health Information, a, National Health Expenditure Database (Ottawa: CIHI, 2004). * The addition of the three categories may not add up to exactly 100%, but have been rounded up for visual purposes.

The data in Table 2 demonstrates the expected shift in British Columbia's health expenditures during the 1990's. Specifically, the financial resources allocated to hospitals from the health budget declined by almost 5 percent, while expenditures going to other parts of the system, increased by just over the same margin as suggested by *New Directions*. At the same time, no significant change occurred to the resources allocated to finance physician services and prescription drug coverage. The shift in funding appears to indicate that the health expenditures are indeed being distributed differently in British Columbia's health system. Therefore, as measured by the health budget spending patterns, regionalization has indeed restructured health care in British Columbia. Although the health budget spending data does not attribute the restructuring to regionalization alone, the shift in health care expenditures does suggest a strong correlation.

This conclusion must to be treated with some caution, however. For while it is important to note that the null hypothesis, which states there is no relationship between regionalization and the redistribution of health spending 'closer to home,' can be rejected, to this point the study has only shown that the restructuring of British Columbia's health system shows some correlation to the independent variable.

To summarize part one, evidence to date indicates the restructuring of British Columbia's health system during the 1990's has attained a key goal of regionalization. In particular, the test of hypothesis one, whether regionalization—as measured by health expenditures—has shown that health

care has been restructured by moving health care out of institutional settings and bringing it 'closer to home:' all other spending. In itself, cost-shifting (i.e. from hospitals to all other spending), is not a very significant finding. Instead, a more detailed examination of the impact of regionalization is required to determine if this restructuring has changed the way in which the health care system operates. The following sections seek to explore this relationship.

PART THREE: HAS REGIONALIZATION MADE A DIFFERENCE?

Answering the first hypothesis has facilitated the attempt to find out the impact regionalization has had on British Columbia's health system. It is only a start, however, to show that regionalization has restructured the health system. What is more interesting is to explore whether the restructuring has changed how health care operates.

A number of prominent observers have argued that changing the way health systems operate is very difficult to achieve due to a series of institutional legacies and very powerful interests (Wilsford, 1994; Tuohy, 1999; Tomblin, 2002). To say anything meaningful beyond what is already known will require establishing a connection between the restructuring of health care 'closer to home' and if there has been any change in health system operation. Evaluating the impact of regionalization therefore involves finding out whether any changes have occurred in how British Columbia's health system functions. The study conducted by Church and Barker (1999) is particularly instructive in this regard. Their research on regional health systems not only indicates the difficulties that must be overcome in order to show that regionalization has actually improved provincial health care, but it also provides an analytic framework with which to assess the impact of regionalization on a provincial health system. These problems are identified as follows:

- 1) The integration and coordination of the administration and delivery of services;
- 2) Consolidating the funding mechanisms;
- 3) The information needed to develop indicators and measurements for meaningful outcome evaluations;
- 4) The accountability of citizen participation mechanisms; and
- 5) The potential to become dominated by local, professional or even special interests.

Tomblin (1999), however, has argued that the main problem facing Canadian health care is the dominance of physicians and the power of the bio-medical model of care. Therefore, it is unrealistic to expect any single reform to address issue five, which will likely require an entire systemic change to the way health care is funded and delivered to be resolved. Based on this understanding, this project will only address the resolution of the first four issues. The second half of this project will argue that although regionalization has restructured British Columbia's health system, the way in which the health care system operates has not undergone significant change.

Hypothesis two

Identifying that regionalization has restructured health care in British Columbia represents an important step in assessing the impact of this phenomenon. Yet, given this understanding, a second hypothesis is needed to

estimate the affect moving health care out of institutional settings and moving it 'closer to home' has had on that province's health system in the 1990's. This hypothesis is set out below.

Hypothesis two: The regionalization of British Columbia's health care system which moved health care 'closer to home' has not changed the way in which health care operates in that the first four problems of regionalization identified by Church and Barker (1999) still exist.

To evaluate this hypothesis a must be found to conceptualize and then measure the persistence of the problems identified by Church and Barker (1999). How this was accomplished is described in the following section.

Testing hypothesis two

The test for hypothesis two originates from the problems with regionalization identified by Church and Barker (1999). This section of the project seeks to determine if the health system has been able to overcome those difficulties and actually change the way in which the health care operates, rather than just the way it was structured. The operationalization of the dependent variable for hypothesis two occurs through the explicit mention of these problems in provincial government publications and newspaper reports. If it is found these challenges are mentioned often, then it is very likely that there has not been very much change in how British Columbia's health system works. Based on qualitative research conducted in government

publications and newspaper reports in the Vancouver Sun, Province and Times-Columnist between 1993 and 1999, the project discusses each of these problems in turn.

Some mention needs to be made as to why these papers were selected. First, an indexed and electronically retrievable archive is available for each paper for the time period under investigation. Second, each of these papers not only report on the occurrence of activities in British Columbia's most populated areas but also across the province as a whole. Further, as major dailies they have the ability not just to chase news but to do investigative journalism as well. It stands to reason that if regionalization was not very effective in overcoming these problems, there would be mentions of these problems in those publications. A frequency table that documents the number of mentions for each problem is also provided to visually represent the findings.

Problem one: integration

Possibly one of the most contentious areas of provincial government activity, health system reform is a highly complex task, often fraught with a number of difficulties. Obtaining integration is one such difficulty health systems seek to alleviate. Regionalization sought to attain integration by consolidating the hundreds of administrative units, decision making bodies

and service delivery entities in the provincial health system under the authority of more community oriented structures. A survey of the literature suggests that the concept of integration refers to a process where different parts of a health care system are brought together to reduce service and administrative duplication, eliminate redundant functions and improves the way the system works (Kernaghan and Siegle, 1999; Sinclair, 2000; Sobczak, 2002).

For its supporters, integration is premised on the notion that economies of scale can be achieved by amalgamating all of the administrative, decision making and service delivery aspects of health care—like individual decision making boards such as a hospital board—into much larger operational units. It is thought that integration will promote a seamless health care system that can obtain cost savings, improve responsiveness (British Columbia, 1993, 1994, 1995; Hurley, Lomas and Bhatia, 1994; Lomas, Woods and Veenstra, 1997) and reduce or eliminate the fragmentation of multiple delivery systems (i.e. acute, continuing care and community health care services).

Those in opposition, however, disagree with this perspective of integration contending that the evidence in favour of this argument is mixed and replete with problems. Church and Barker (1999) for example mention several of these challenges. The authors argue that the amalgamation and closure of previously functioning local governance bodies has typically followed many of the efforts to achieve health system integration. When this

happens, not only do communities lose their local health institutions—such as hospitals—but the closures may also force residents to travel outside of their local communities to receive care. In addition, these communities may lose their local autonomy to much larger governance bodies. Despite these disputes, one thing that both detractors and defenders of regionalization agree on is that there is a need for better integration in Canada’s health system.

This problem is measured as follows. By examining government publications and newspapers reports, the project contends that if there are mentions that trouble developed in joining the administration and governance structures of health care delivery in British Columbia under the authority of regional entities, then it is highly probable that the problem of integration was not resolved before the end of the decade. A search from 1993–1999 indicates integration was discussed in all three major dailies. These mentions are documented below in Table 3.

Table 3: Operationalizing Integration

Problem	Number of Mentions of Problem	
	Frequency	Percentage
Integration	84	43.8%
Total	193	100%

The research shows 84 mentions of problems with achieving integration. These mentions are those referred to problems with achieving integration in the title, abstract or text of each newspaper reports. In sum, some 84 reports or 43% percent of 192 articles, each of which related to problems with regionalization in British Columbia, were found to connected to problems with integration.

In addition to the newspaper reports, publications from the provincial government have also discussed problems with achieving integration. For instance, in the 1997 review of the regional governance and accountability mechanisms, the Auditor General's Office found that several aspects of the regional objectives were not being met. In particular, since many of their responsibilities were shared, there was some confusion about how to integrate services that overlapped between the CHSS and CHC's (British Columbia, a, 1998). The report also mentioned that although most of the health authorities generally had a good idea of what their responsibilities were in the new regional health system, it was not always clear who was responsible for what. In expressing some concern about how regionalization was falling short of achieving integration with sufficient clarity, the report cited the provincial government as being to blame for not articulating clear guidelines as to what integration was trying to accomplish.

At first glance, integration appears to be a serious problem of regionalization in British Columbia. Both the Auditor General's report and newspaper articles point to the difficulties in achieving this objective. Yet, it

is important to note that much of the evidence related to the occurrence of any problems with integration was anecdotal. That is, many of the mentions of integration simply refer to the potential problems that may emerge as a result of regionalized health care, rather than actual ones.⁹ Clarification from the Auditor General, however, indicates that if indeed any problems did occur, they were due to a lack of direction and leadership from the provincial government (Wigod, 1994; British Columbia, 1995; Palmer, 1995; Fayerman, 1996; British Columbia, 1998).

Problem two: consolidation

No debate on the effectiveness of health system reform would be complete without a discussion of money. Church and Barker's second problem with regionalization directly recognizes several aspects of the challenges of funding health care. In the past, many provincial funding models for the budgeting of health services, each of which typically reflected past budgeting practices, were centrally determined at the ministry level. To some extent, this means that health resources were allocated to hundreds of hospital and provider groups based on past utilization patterns. As part of the transition towards a regional health system, British Columbia also sought to

⁹ See table 7: The Problems with Regionalization, which shows the number of articles that do not actually discuss any problems with regionalization.

shift how these funding practices worked. Among other prominent scholars, Lewis (1997) has characterized the consolidation of funding mechanisms as changing the funding practices for health services.

Many of the changes to the funding practices for health services in British Columbia occurred through a decentralization of financial authority. Discussing how important money is to assessing the problems with regionalization, the literature has shown that one of the main ideas behind consolidating the health service funding mechanisms is to make RHA's responsible for allocating the funds that pay for the provision of health services in their communities, as opposed to the ministry of health distributing these funds (Hurely, Lomas and Bhatia, 1994; Lomas, 1996; Lomas, Woods and Veenstra, 1997). Based on this thinking, consolidating the health service funding mechanisms can be defined as joining the number of past health budget allocations, each of which had been administered to a range of providers in the region, into one lump sum.

Research has shown that a number of difficulties may result from the shifting of responsibility. For example, evidence in other jurisdictions has shown that shifts in authority have on many occasions resulted in a variation of access to insured services (Sheill, 2002; Mitton et al, 2003). Moreover, patients do not always obtain health services in their own region. Nor is the range or availability of similar services always equal between jurisdictions. Combined, these challenges appear to indicate that the new health service funding mechanisms may neglect the fact that the entire range of health

services may not fall under regional planning and budget projections. Following this line of thinking, in seeking to measure whether there were any problems with consolidating the funding mechanisms for health services in British Columbia, a key indicator would be whether the RHA's were indeed responsible for funding the entire range of services within their jurisdictions. If there are instances where this is not the case, then there is a very strong likelihood that there were some problems with consolidating the funding mechanisms in British Columbia.

Since many of the RHA responsibilities were negotiated with the province (British Columbia, 1995), determining the funding responsibilities of each RHA would be complicated. In this regard, it must also be noted that the province was also responsible for highly specialized health services, known as tertiary services. To be carried out, these specialized services typically require teams of experts with the necessary skills, training and sophisticated technology; some examples are cardiac surgery, high risk maternity care and renal dialysis. Many of these services cannot be provided effectively in most regions, however, because the need for them is so low that it would not be very cost effective to maintain teams of specialists in any given region. This means that the province was to be responsible for providing those services the regions could not. Therefore, it is very likely that RHA envelopes did not consolidate all of the health service funding mechanisms.

Given that this variation from regionalization is logical and inevitable, another test is required. A better approach is to focus on special allocations of funding to regional health authorities for purposes defined by the province. When the province makes special funding allocations to individual institutions or programs or earmarks new resources to a particular use within the health system, these efforts undermine the supposed autonomy and consolidation of budgetary powers that ought to be vested in the hands of regional authorities. In a completely consolidated system all provincial funding would go to the regional authorities, which would then independently determine how the resources were to be spent. Based on this understanding, consolidation can be operationalized in the following way. If there are mentions of special resource allocations or instances of earmarked funding in the articles that discuss the problems with regionalization, there were probably ongoing problems with consolidating the funding mechanisms for regional health services in British Columbia. A search of the three major newspapers reveals a number of instances where special funding was announced. Table 4 on the following page illustrates these findings.

Table 4: Operationalizing Consolidation

Problem	Number of Mentions of Problem	
	Frequency	Percentage
Consolidation	26	13.5 %
Total	193	100%

The data indicates that consolidating the funding mechanisms of British Columbia’s regional health system proved to be problematic. In all, 26 instances of special funding announcements or 13.5% of all the articles found relating to problems with regionalization show ongoing problems in this area. These are discussed in more detail below.

In one of the first instances of special funding created after regionalization occurred, the province created the \$42 million dollar “Closer to Home Fund,” which granted funding to community based projects to alleviate the pressure on British Columbia’s hospitals (Cleverly, 1994). Along with trying to ease the transition from institutional to community based care, the province also announced funding that affected special populations. For example, Health Minister Joy McPhail announced in 1997 that the province would start paying registered mid-wives to deliver babies in the public system (Bell, b, 1997). The Premier also announced \$28.5 million in 1999 to expand the scope of services and treatments for women and children in British Columbia (Morton, 1999). This funding was on top of an earlier

allotment of \$3.25 million to fund more surgeries at Children's Hospital and another \$2.4 million to assist paying for services offered at Hudson House, a residential facility for children with eating disorders (Morton, 1999). Most prominently, however, several other funding announcements were dedicated to reducing the waiting times for surgery and hospital overcrowding. In addressing the former, McLellan notes two examples of these instances to improve the wait list for heart surgery, once in April 1996 when the province announced an injection of \$7.325 million dollars, and the other in February 1997, with an additional \$6.5 million (1997). Both Sieberg and McInnes (1999) and Lee (1999) discuss the later, with announcements of \$6.5 million and \$26 million respectively.

Problem three: information requirements

Often poorly discussed in the context of health care reform, the use of data, evidence and information has become an increasingly important part of Canada's provincial health systems. Information is an extremely valuable tool that helps to guide and inform the future of Canadian health care. Essential for the operation of highly quality health care systems, health information is a very powerful resource, which has a number of important uses. Specifically, information can:

unlock the cures to many of today's illnesses, identify the genetic source of chronic illnesses, give health care providers access to the latest and best information on new treatments or drugs, improve the quality and safety of care within the health care system, and most importantly, empower patients to manage and maintain their own health (Canada, 2002).

Without it, it is generally accepted that many health related decisions will suffer from a variety of limitations and will not achieve optimum results (Lindquist, 1988). To benefit from the data needed to maximize the effectiveness of health service delivery, however, the necessary health information infrastructure must be in place.

Prior to the implementation of regional health systems, much of the information collected in Canadian health care was oriented towards keeping track of system inputs. The amount of financial resources used to finance the system for example, goes back to the mid 1970's. Yet, just as regionalization sought to improve the effectiveness of British Columbia's health system, the province must improve and make better use of all kinds of health related information. In other words, obsolete data collection practices needed to change to reflect the needs of regionalization, which would provide decision makers and citizens alike with access to the best available data to inform their decisions. Based on this understanding, and the fact that regional systems are shown to have more complete information requirements (Church and Barker, 1999), it seems likely that the transition to a regional health system in British Columbia would require more comprehensive information and data collection practices. Among other things, this would mean that the government must have developed new ways to collect, use and report on how health

information was used in the province. Because this is more of a cultural change in how government works, operationalizing this variable will probably be more difficult than the other problems; however, determining whether there were problems with the information requirements necessitates finding out if any steps taken to improve the provincial data banks of information. Therefore, operationalization will occur not only through newspaper mentions of whether the province undertook activities to change the way in which information was collected and used. In addition, government publications will also be searched to investigate the same phenomenon. The instances where information was mentioned in the newspapers are listed in table 5 below.

Table 5: Operationalizing Information Requirements

Problem	Number of Mentions of Problem	
	Frequency	Percentage
Information Collection/ Dissemination	8	4.2 %
Total	193	100%

As table 5 indicates, very few mentions about the information requirements needed for regionalization occurred in the newspapers from 1993 -1999. The data in this area is somewhat incomplete. A search of the literature from the province, however, shows more mentions of how the

provincial government sought to improve their data collection and information systems. For example, the annual health reports show a number of significant initiatives undertaken to improve British Columbia's health information and data collection practices during the 1990's. The 1992/1993 annual report identified that there was an urgent need to develop better data collection practices and formally announced a plan to create the Health Information Management Project (HIMP) the following year. Formulated to ensure that the necessary health information infrastructure would be in place to assist regional planning, the HIMP's goal was to improve how health information was collected and used to make better decisions that would improve how the health system worked (British Columbia, 1995).

In addition to the HIMP, the province also undertook other measures to improve the health information infrastructure in British Columbia. Reflecting the rapid pace of innovation as well as the high priority that better health information provided, the Ministry of Health was restructured the fall of 1996 to include an Information Management Division (HMD) (British Columbia, 1997). Primarily responsible for information management strategies, policies, standards and technology initiatives across the province, the HMD developed strategic plans to continually improve health information management standards as well as provided technical support for the Medical Services Plan processing and Pharmacare plan. More informally, new funding was also earmarked in the years that followed in order to encourage research that would provide clinicians, regional governance bodies and the

province with high quality health information and thus allow them to make more effective decisions (British Columbia, 1998).

From all accounts, the 1990's represented a revolution in terms of the availability of all kinds of health related data and information. From the spread of use of personal computers, transmission of instant communications and information retrieval via the Internet, a great deal of progress was made in making health information available to those who needed to make decisions. In addition to improving how information was collected, provincial documentation also indicates that the province started to report health data differently. In particular, the province began reporting on how the health system was performing in reaching publicly stated health goals such as reducing smoking and improving home and residential care by providing detailed information from different parts of the province (British Columbia, 2000). Referred to as performance reporting, these reporting practices were designed to provide a more meaningful way to measure how the health system works. Reporting of this kind is considered standard practice today.

In the end, a search of the available evidence indicates British Columbia took a number of positive steps to address the informational challenge of regionalization in the 1990's. Along with the very few mentions of problems with this aspect of regionalization, reorganizing the ministry and providing special funding and the creation of a department dedicated to ensure better data collection practices, it looks like the province provided the necessary information infrastructure to collect and disseminate high quality

health data, much of which would be used to monitor and improve how the health system worked. Taken together, these efforts can be chalked up as a success for British Columbia in meeting this challenge.

Problem four: accountability

In recent years, accountability is a term discussed increasingly often in the context of health care reform. An extensive literature has developed in this regard, much of which draws attention to the breadth and use of its meaning. The mere scope of the literature points out that there a number of explanations and dimensions of accountability as applied to health care. Despite the broad spectrum of this scholarship, a good deal of the literature makes reference to accountability being connected to improving how health systems work.

A survey of this literature (Fraser, 1995; Emanuel and Emanuel, 1996; Canada, 1998; Davidson, 1999; BCMA, 2000; Woods, 2002) indicates two dominant explanations of accountability. In the first case, political accountability is an explanation that refers to how health system officials are answerable to the public—often through elections—for meeting publicly stated objectives (Fraser, 1995; Davidson, 1999). There is also that aspect of accountability referred to as managerial or administrative. This refers to

whether health system professionals are deemed to be competent in the discharge of their duties, mostly regarding the expenditure of public funds (Kernaghan and Siegle, 1999). Generally speaking, the former essentially refers to high ranking public officials such as the Minister of Health while the latter, addresses health system bureaucrats. Combined, these explanations involve the common thread of being answerable to another party or agent, and taken together, are considered fundamental values of good governance.

To be of any use in operational terms, it is important to note that being accountable implies some form of external control. In other words, accountability is a term that refers to how public servants and/or the organizations to which they belong, are held responsible for their actions; that is, held to account (Fraser, 1995). For the purposes of this project, accountability is defined as the obligation to account for responsibilities conferred. Accountability, however, requires the prospect of some kind of sanctions by those to whom accountability is owed. Put differently, the notion of accountability draws attention to the fact that there is some kind of higher authority to which public servants are required to explain their actions and decisions. As prominent actors in many health systems, physicians for example are held accountable through their membership in professional organizations. Without recognition from this authority, they cannot legally practice medicine. Similarly, it is often assumed that in our political system voters in periodic elections hold elected officials responsible for their actions.

Without sufficient approval from the electorate, political actors do not succeed in attaining office.

In the context of accountability problems with regional health systems, a review of the regionalization literature indicates that RHA's were established as a decision making body by which providers, public officials and managers could be held to account for their actions (Hurley, 1994; Lomas, Woods and Veenstra, 1997; Church and Barker, 1999; Davidson, 1999; Frankish, 2002). As entities responsible for most health care decisions in British Columbia, provincial documentation describes two ways the RHA's are held accountable for their actions. First, as described in two Health Authorities Acts (1993 and 1997), RHA's are accountable to the minister of health through their legislative responsibilities. Second, RHA's are held to account is to their local communities through elections (British Columbia, 1993, 1995, 1998). Yet, when explaining the principles of effective accountability to Parliament, the 1993 report of the Auditor General of Canada described a well functioning and accountable decision-making body as that which undergoes a minimum of change and disruption during the course of carrying out its responsibilities to whom accountability is owed (Canada, 1993). Keeping the Auditor general's comments in mind, change and disruption will therefore be a key indicator of determining whether the RHA's had problems with accountability. Based on this understanding, if the newspaper reports that discuss the problems with regionalization indicate instances where there was a significant degree of instability as to how the

RHA's carried out their responsibilities during the 1990's, then it is also highly likely there were problems with their accountability. Therefore, accountability can be operationalized by the mention of problems with the accountability and stability of the regional health authorities in newspaper reports from 1993 to 1999. The results of this research are displayed in table five on page 55.

Table 6: Operationalizing Accountability

Problem	Number of Mentions of Problem	
	Frequency	Percentage
Accountability/Disruption	40	20.8 %
Total	193	100 %

Indeed research reveals a number of mentions that the stability of the RHA's was a problem during the 1990's. In fact, the sheer number of mentions demonstrates that disturbances in the RHA's carrying out the responsibilities to whom they were owed was very common throughout the decade. In this regard, 40 of the 193 newspaper articles that discussed problems with regionalisation, or 20.8 percent, mentioned instances where disruption occurred.

In addition to these newspaper reports, the provincial government also expressed some concerns in this area. The Auditor General published a report that investigated the accountability of the RHA's in British Columbia. His

report argued these disruptions emerged from three areas; lack of leadership and clarity from the provincial government; the high rate of turnover among RHA membership; and the lack of appropriate qualifications for RHA members. Together, these problems made it very difficult for the RHA's to make informed decisions about the operation of health care in British Columbia.

The lack of leadership and clarity in British Columbia's health system during the 1990's came from two areas. First, the ministry of health annual reports reveals there were six different ministers of health since the government announced its intentions to adopt a regional health system in 1993.¹⁰ Loosely defined as a public official who provides direction and influences how people under his/her guidance meet government and ministry objectives (Dyck, 1996), the minister of health is the government person in charge of setting provincial health policy. As the formal head of a government department or ministry, the minister is a leader in the government caucus that bears significant responsibility for the actions of their department. Students of parliamentary systems of government may recognize this notion as ministerial responsibility. But since leadership styles differ, and the literature shows that highly complex organizations often stagnate without consistency (Kernaghan and Siegle, 1999), with an average term of less than a year, the amount of change at the ministry of health suggests that many

¹⁰ See appendix 2 for a complete list of Ministers and Deputy Ministers of Health during the 1990's.

ministers were not in their positions long enough to carry out their responsibilities in a responsible fashion.

Second, the provincial government also failed to be clear about its vision of regionalization. Among other things, the lack of clarity meant the RHA's were unsure of how to meet the goals of regionalization as communicated by the province (British Columbia, 1998). Reports from the three major dailies confirm these challenges, suggesting that the province was to blame for articulating vague performance criteria (Wigod, 1994; Palmer, 1995; Fayerman, 1996). The difficulties with the ministry of health were also reflected at the RHA level. For example, newspaper reports indicate several RHA's were either dismissed entirely or had a high rate of turnover among personnel (Young, 1995). In fact, the problems were so severe and disruptive that by the Spring of 1997, more than a dozen local hospital administrators and were either fired (Lee, a, 1996), resigned (Morton, 1996) or outright refused to accept the shift in authority from their hospital boards to the RHA's (Rinehart, 1997; Rinehart, a, 1997). Understandably, instability at the management level made it very difficult for the RHA's to carry out their responsibilities with reasonable continuity and thus was indicative of the turbulence in this area.

With respect to the qualifications of RHA members, concerns emerged from the Auditor General, which identified several problems with the governance and accountability mechanisms in British Columbia health system after the adoption of regionalization in 1993. Specifically, the Auditor

General was highly critical of the interim authority members and their capacity to make decisions about the operation of the health system (British Columbia, 1998). Based on his investigation, the report cited two major concerns. The first problem relates to the fact that many first round of board members did not have the appropriate qualifications to make informed decisions about large sums of public money. Rather than due to their knowledge or experience about the administrative or business end of the health system, members were chosen because of specific ethnic, gender and regional characteristics (British Columbia, 1998; Beatty, 1998). Owing their appointments to the minister of health, a second concern here is that the RHA's would make decisions that did not reflect community preferences, but would instead prioritize those issues important to the ministry. Writing on this very issue, Lomas (1997) has referred to this dilemma as not knowing whether the RHA's would be "local mirrors," or what he called "local enforcers" of government policy.

Perhaps the most explicit instance of disruption and sign of problems with accountability in British Columbia's health system came with the demise of *New Directions*. As it became increasingly clear that public concerns about the election processes of the RHA's could no longer be managed effectively, the province announced that *Better Teamwork* would alleviate the shortcomings the previous policy had been unable to address. In the final analysis, however, the announcement of *Better Teamwork* signalled the end of political accountability in British Columbia's health system. Instead, with the

move toward RHA appointments made by the Minister of Health, the regional plan moved toward a managerial form of accountability. Essentially, the policy change meant the RHA's were accountable to the Minister of Health, instead of the local communities as initially planned.

The overall picture appears to indicate problems with accountability in British Columbia's regional health system during the 1990's. To reiterate, it has been observed that both the ministry of health and the management and personnel activities of the RHA's experienced a great deal of disruption, which made them difficult to be accountable. In this situation, the RHA's were without clear guidelines of their responsibilities, and it seems the government handed over almost half of the provincial health budget to people who not only lacked direction but whose unaccountability was exceedingly murky. They were asked to make critical decisions about health care in the province, without any knowledge or expertise in allocating public money. Thinking about the problem in this way, the disruption and instability could be seen as an attempt to shuffle accountability, rather than make it an important objective of regionalization.

Part two of the project has sought to determine what if any impact regionalization has had on the health system in British Columbia during the 1990's. To summarize, the second hypothesis tested whether regionalization affected health care in British Columbia. The test for this hypothesis originated from the problems identified by Church and Barker (1999). Qualitative research using government publications along with the Times-

Columnist, Vancouver Sun and Province newspapers shows that the problems with regionalization identified by Church and Barker (1999) were not entirely resolved. Yet, despite the sustained incidence of most of these challenges, it appears as if there was some progress made. In other words, although regionalization did not significantly alter health care operation in British Columbia, it has been shown to have had some impact in mitigating the problems with how the provincial health system operates.

Table 7: Mentions of Problems with Regionalization in the Three Dailies

Problem	Number of Mentions of Problem	
	Frequency	Percentage
Integration	84	43.8%
Accountability/Disruption	40	20.8 %
Consolidation	26	13.5 %
Information	8	4.2 %
Missing*	59	30.7
	(217)*	(113.0%)*
Totals	193	100 %

* These numbers do not add up to the actual totals because a number of newspaper articles documented a mention of more than one problem. For simplicity, only the problem being looked for was coded as present. If articles did not mention any of the problems, it was coded as missing.

As the table shows, there are a number of instances where the problems discussed by Church and Barker (1999) are mentioned in newspaper reports. In fact, while it is evident that the research suggests that the province was able to improve on how it collected and used information in the regional

health system, the number of mentions of problems with accountability and integration are extremely problematic. Based on these findings, the project finds that the health system was not entirely able to overcome the problems with regionalization identified by Church and Barker. Instead, because those problems persisted, it is highly unlikely that there was any significant change in health care operation in British Columbia during the 1990's.

CONCLUSION AND OPPORTUNITIES FOR FUTURE RESEARCH

The main purpose of this project has been to investigate regionalization in the province of British Columbia during the 1990's. This has been accomplished by dividing up the project in three parts. Part one is comprised of three sections, the first of which generally laid out the project organization, its data, methodology and purpose. Section two discussed much of the important Canadian literature related to regionalization. Based on that investigation, the project put forward a practical definition of regionalization. By examining the health care expenditure patterns from 1993-1999, the next section measured whether regionalization was able to bring health care 'closer to home' in more than just the rhetorical sense. The project examined three spending categories. Here, the percentage of the health budget going to spending on hospitals was compared to the percentage of the health budget that went to all other spending during the 1990's. In addition, the spending to physicians and drugs was used as a constant and did not significantly change. The comparison showed expenditures to all other spending increased, while hospital spending declined during the 1990's. By shifting the location of funding, in sum, part one of the project found that regionalization not only restructured the management and governance of the provincial health system, but it also was able to move health care out of costly, expensive institutional settings such as hospitals.

Regionalization's effect on British Columbia's provincial health care system has not been very well understood, however. Using the problems identified by Church and Barker (1999) with regional health systems in Canada, part two set out to measure whether any change occurred to British Columbia's health system since regionalization took effect. In section four, the problems put forward by Church and Barker were not only conceptualized, but also operationalized with qualitative research from newspaper reports and provincial government publications. The findings in this section indicate that although regionalization changed the structure and management of British Columbia's health system, it did so without extensively changes occurring to how health care operates in the province. Instead, the health system continued to suffer from a number of challenges even after regionalization was implemented. But rather than suggesting that regionalization was not able to make any improvement at all in how health care worked in British Columbia, the project instead finds that there was some progress made in attempting to resolve these difficulties. British Columbia was able to alleviate some, but not all of the problems with how health care operate.

In addition to the general findings, the project may also be helpful in other research settings. For example, the analysis and conclusions may guide future research on regional health systems and the experience in British Columbia. It will be recalled that British Columbia's regional reforms implemented during the 1990s had some unique features. For example,

British Columbia implemented a three tier system of governance for the health system. In addition to the multiple layers of decision making, elections were also planned for the RHA membership as well. But, because a number of problems emerged with the way in which this configuration would have altered traditional government accountability practices, As a result, the British Columbia regionalization experience provides a unique opportunity for scholars to learn what was achieved here, but also for other jurisdictions to benefit from our health reform experience. In this way, other provinces may also learn what worked and what did not so as to hopefully not repeat the same mistakes and work towards improving how provincial health systems operate.

It is also worth noting that while Church and Barker's framework provided a useful approach to assess regionalization in British Columbia, there were also some problems with using it. Specifically, this project was not able to address problem five, which argued that the RHB's were susceptible to external influences. Given the power of vested interests in provincial health care and the dominance of the bio medical model of care, it was unrealistic to assume that any one reform would resolve problem five. Therefore, the project could only address their first four problems. Taken together, these issues provide reason for some caution to be applied when interpreting the results of this project.

Nevertheless, the project does provide those involved in health care decision making and students of health research a model to follow when

learning more about a methodology to use when conducting health system research. In addition, the project may be helpful to those interested in learning more on the impact of health reform on existing provincial health care systems. In this regard, future work may extend and refine the analysis, and improve the methodology allowing it to be used to assess other regional initiatives as well, so that eventually, a comparative evaluation of regionalization across Canada may be possible using this or another similar method.

APPENDIX A: PARTIAL REGIONALIZATION TIMELINE

Date	Event
1990	The Social Credit government of Bill Vander Zalm establishes the Royal Commission on Health Care and Costs (Seaton Commission) to review the provincial health care system and make recommendations for its reform.
1991	The Seaton Commission releases its two-volume report on the British Columbia health system, <u>Closer to Home</u> . Citing a number of problems, the commission recommends regionalization as a way to improve the management and delivery of health services in British Columbia.
Feb, 1993	Minister of Health Elizabeth Cull announces “New Directions for a Healthy British Columbia,” the ministry’s strategic plan for reforming the provincial health system.
1993	Bill 45, <i>Health Authorities Act</i> passes in the provincial legislature, creating the legal framework for regionalization to proceed. Among other things, the Act outlines the authority of Regional Health Boards, Community Health Councils and Ministry of Health
Spring 1993	Work begins on the development of the creating 20 Regional Health Boards and 82 Community Health Councils. Ministry coordinators start implementing a new funding structure and policies that stipulate the core services and standards for both RHB and CHC’s
July 1996	New Minister of Health, Joy McPhail, announces a temporary hold on the process of regionalization, appointing the Regional Assessment Team to examine the cost-effectiveness of implementation.
October 1996	The Regional Assessment Team presents its findings to Health Minister Joy McPhail, recommending 20 changes to the regional health system
November 29, 1996	The Health Minister announces the governments’ intention to implement a new plan for regionalization in BC, <i>Better Teamwork, Better Care</i> .
April 1, 1997	As a partial response to the criticism of the Regionalization Assessment Team, the province creates 11 Regional Health Boards (RHBs) in urban/semi-urban areas, 34 Community Health Councils (CHCs), and 7 Community Health Service

April, 1997 Societies (CHSSs) in rural areas.
Full responsibility for the management and governance of most health care services in British Columbia is transferred to the 52 remaining RHA's.

APPENDIX B: MINSTERS OF HEALTH IN THE 1990'S

Year	Minister	Deputy Minister
1990	John Jansen	Kriysia Strawczynski
1991	Bruce Strachan	Chris Lovelace
1991	Elizabeth Cull	Doug Allen
1993	Paul Ramsey	Laurie Macfarlane
1995	Paul Ramsey	Chris Lovelace
1995	Paul Ramsey	Ken Fyke
1995	Paul Ramsey	David Kelly
1996	Andrew Petter	David Kelly
1996	Joy MacPhail	David Kelly
1998	Penny Priddy	David Kelly
1999	Penny Priddy	Don Avison
1999	Penny Priddy	Leah Hollins
2000	Mike Farnworth	Leah Hollins

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