Striking a balance between decentralization and centralization in public health systems

NCCHPP Webinar

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CIHR IRSC
Canadian Institutes of Health Research
Instituts de recherche en santé du Canada

Background

- The COVID-19 pandemic has reinforced the importance of resilient health care and public health systems that are effective and responsive
- Recent reforms to public health systems governance, organization and finance in Canada have not been systematically evaluated

This study examined financing, governance and organization of public health systems in Canada to inform future reforms

Public Health Systems

The collection of public sector organizations with a mandate for public health

Enablers/Structures:

1. Organization
2. Governance
3. Financing
4. Workforce

Core functions:

1. Health Intelligence – Surveillance and monitoring
2. Health promotion
3. Health protection
4. Disease prevention

Project Overview

Phase 1

Public health system profiles

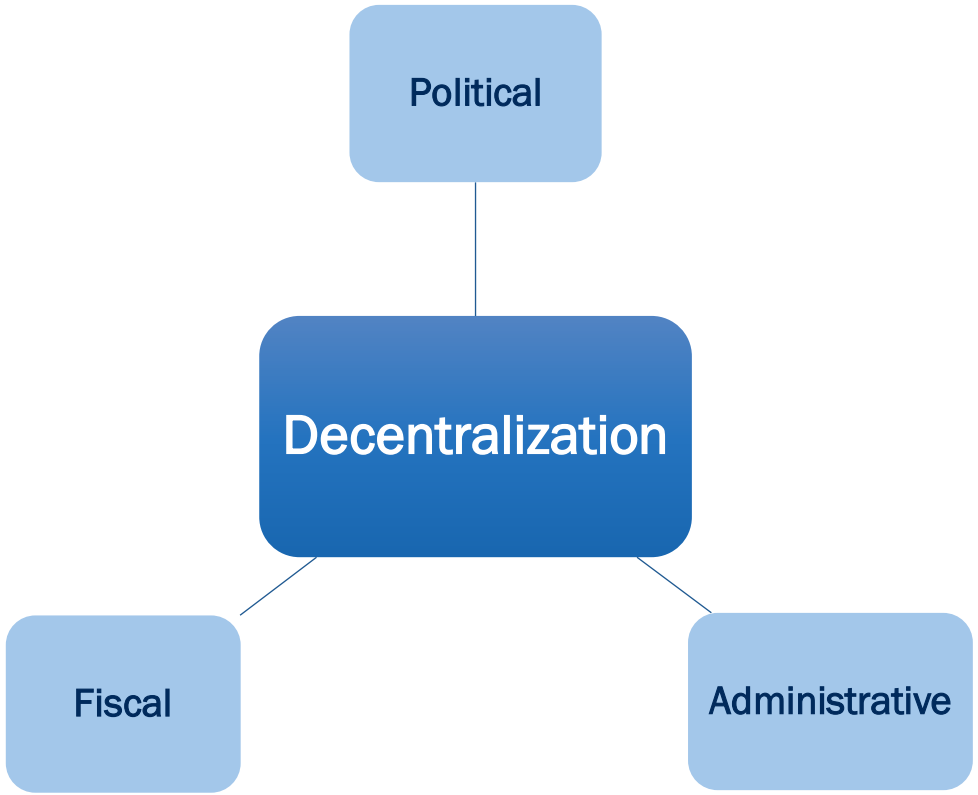
Phase 2

Case studies with interviews with public health leaders, in Québec, Ontario, and Alberta

Phase 3

Inform development of a **performance measurement framework** for public health systems

Health System Decentralization



Why decentralize?

- Experimentation, learning and competition
- Policies and programs reflect local populations

Why centralize?

- Reduce regional inequalities
- Increase efficiency (economies of scale, fewer layers of bureaucracy)

Trend toward centralization in recent health system reforms

	Alberta	Québec	Ontario
Health Care	**Centralized** Alberta Health Services [AHS] 2008	**Regionalized** Removed regional layer of governance in 2015 -22 CISSS/CIUSSS	**Mixed** Centralized -- Ontario Health (2019) Decentralized – Ontario Health Teams (2019+)
Public health	**Centralized** AHS	**Regionalized** -18 Regional Public Health Departments in 22 CISSS/CIUSSS	**Decentralized** 34 local Public Health Units (PHUs)

CISS = Centres Intégrés de Santé et de Services Sociaux (Integrated Health and Social Services Centres)
CIUSSS = Centres Intégrés Universitaires de Santéet de Services Sociaux (Integrated University Health and Social Services Centres)

Examining public health systems with case studies

In-depth interviews with public health system leaders in three provinces (n=58)

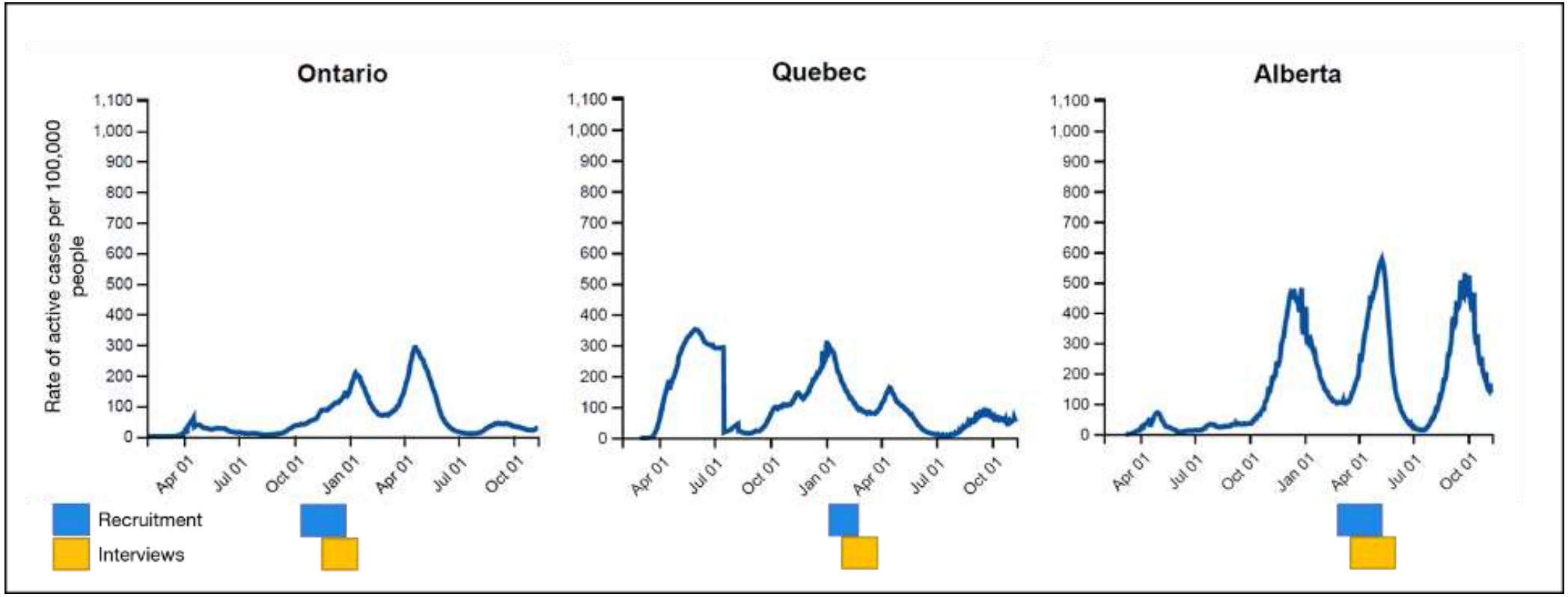


Figure 1. *Recruitment and interview timeframes in relation to the rate of active cases (per 100,000 people) in Ontario, Québec, and Alberta from February 2020 to October 2021.*

Data source: Public Health Agency of Canada

Key Limitations and Caveats

- Unable to separate decentralization from integration (public health and health care)
- Unable to establish causal relationships
- Our focus on public health systems leaders misses other perspectives and outcomes

Drivers of health system centralization reforms

Reforms in all three provinces aimed to contain costs

- ↓ what were portrayed as excess administrative costs associated with management/administration
- ↓ duplication of activities and addressing workforce capacity limits in smaller jurisdictions

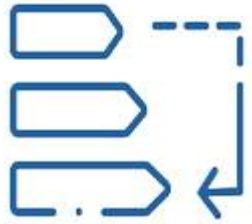
Some unique findings in Alberta

- Driver - to shift power away from regions in major urban centres
- Impacts - some positive effects with reduced duplication of services and increased standardization

Impacts of health system centralization reforms

Detrimental effects on intersectoral and community-level collaborations

- Centralization ”severed” those relationships with community
- The promise of integrated acute care and public health not widely seen in Québec



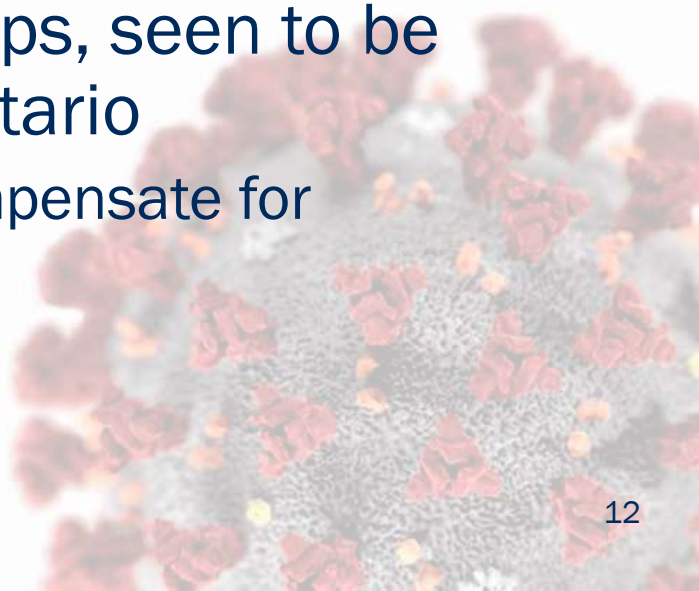
Deprioritizing public health operations and contributing to workforce precarity

- Some public health functions prioritized (e.g., health protection) at expense of others (e.g., health promotion, tobacco control)

(De)centralization and the COVID response

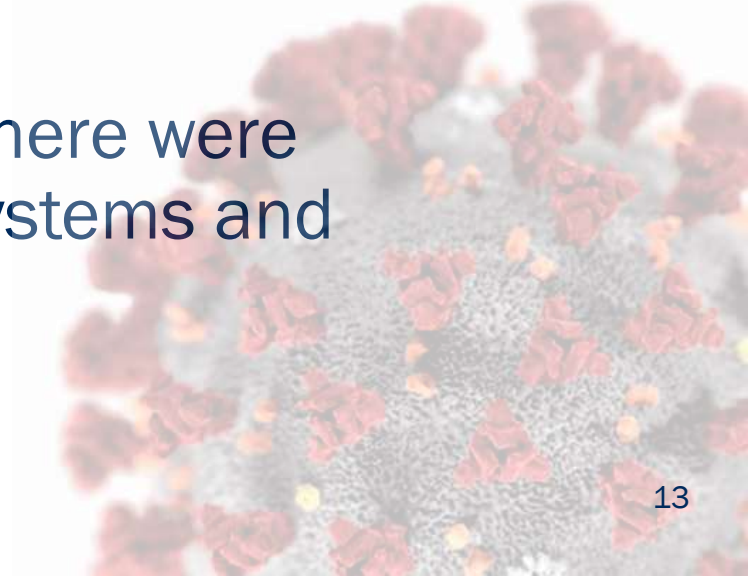
- More centralized systems in Québec and Alberta seen to have more coordinated, swift responses, and rapid reallocation of resources than in Ontario
  - In Québec and Alberta, provincial emergency coordinating centres were interconnected with regional emergency operations centers

- The ability of Medical Officers of Health to communicate openly, share information publicly, and establish partnerships, seen to be more constrained in Québec and Alberta than in Ontario
  - Local level leadership/authority in Ontario helped to compensate for limited provincial coordination and support



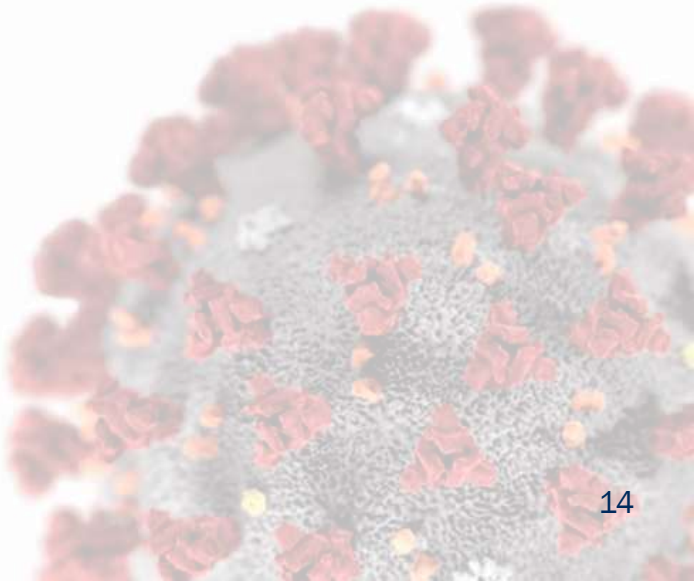
Cross-cutting challenges with the pandemic response

- Impeding COVID-19 responses across the jurisdictions (i.e. regardless of decentralization):
  - Perceived opacity in provincial decision-making
  - Existing underinvestment in public health
  - Agencies supporting First Nations and Inuit communities navigated mandate ambiguity of federal or provincial government actors
- Existing underinvestment across systems meant there were workforce limitations and outdated surveillance systems and technologies



Cross-cutting impacts of the pandemic on public health systems

- Intensified collaboration within and beyond health system
- Increased proximity between public health and health system leaders
- Changes in workforce capacity
- Increased use of information systems and digital technologies
- Increased appreciation for public health work



Key Messages

- All provinces struggle to strike the right balance between central/coordinated public health functions and local responsiveness/ variability
- Public health systems depend on strong partnerships: resources and infrastructures are needed to support these partnerships at local level
- Priorities across provinces include investing in public health IT and workforce, while preserving and improving mechanisms for intersectoral partnership

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