Therapeutic Regions

by

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BA (hons.), York University, 1973
MA, York University, 1979

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of

DOCTOR OF PHILOSOPHY

in the Department of Geography

Supervisory Committee

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Abstract

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Health regions in Canada are primarily associated with the rationalization of conventional, historically expensive provincial health care systems. At the same time, it is unclear what contribution health regions make to advancing health system reform, particularly health-promoting activities. This work sets out to understand the relationships between regionalization and health-promoting activity by studying two health regions in Canadian provinces that have different approaches to regionalization (British Columbia and Ontario).

I use a constructivist grounded theory methodology (Charmaz, 2006) to analyse data from nineteen key informant interviews with senior management working in the two regional health authorities and in provincial health organizations. The iterative analysis of the empirical data and the review of corporate documents from both regional organizations result in the identification of three core themes grounded in the data.

The dominant theme emerging from the analysis is identified as *place-making* referring to a region's ability to facilitate health-promoting activity by making the region a place with special meaning and resonance for the populations served. The other two themes are *creating space within organizations for health-promoting activity* and *developing networks*. The former refers to a region's willingness and ability to operationally support health-promoting activity and the latter refers to efforts undertaken to establish relationships with other organizations in the health-promotion and healthcare networks. I conclude that these three themes characterize critical components of a therapeutic region.

A therapeutic region suggests a conceptualization of regional health authorities (RHAs) in which priority is given to health-promoting activities, alongside an entrenched curative healthcare agenda (the medical model). A therapeutic region is conceived of as a region that implements policies and develops structures aimed at achieving improvements in the overall health status of the population it serves. In this research I develop a four-cell matrix to frame the theory of therapeutic regions. One axis represents a continuum of place-making, while the second axis reflects a continuum depicting how regions develop the two other themes -- one extreme represents a piecemeal or patchwork approach, and the other an integrated strategic approach.

The implications of this research relate to practice and policy. The practice of improving the health of the population served requires regions to open pathways, and remove longstanding barriers by making place-making core to all community engagement and develop health-promoting activity within their organizations and their networks. Policy-makers need to bring clarity to the regions' role in health-promoting activity. This research indicates that health-promoting activity, innovation and progress occur when a region has the ability to manage both conventional, curative health care and health-promoting activities. Whether that is through direct governance or new ways to bring together decision-making, service co-ordination and evaluation is a subject for future work.

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Acknowledgments

I acknowledge that without many years of support, encouragement, tolerance and love from my wife, Mary Claire, this would not have been possible.

Dr. Denise Cloutier has provided extraordinarily strong and consistent academic insight and support throughout. Her supervision has been encouraging, facilitating, prodding and challenging; usually all at the same time!

I also extend my sincere appreciation to all members of the committee. Each has provided valuable input and perspective that have been extremely helpful at important times throughout the research process.

Dedication

The fact that we get an equal chance of being cured once ill because of equitable access to care does not compensate us for our unequal chances of becoming ill.

(Daniels, 2008, p. 142)

Chapter 1: Introduction

Provincial health policies in Canada aim to balance the cost of providing universal access to a single-payer health system with quality population health outcomes. A major shift in policy occurred in the 1980s after several landmark studies suggested that the health of Canadians was not determined solely by their ability to access the conventional healthcare system dominated by hospitals and doctors. A healthy lifestyle, human biology and physical environment were also seen as important non-medical determinants of health that were usually under the purview of the public health agenda (Kirk et al., 2014). The result was a bifurcated policy path addressing cost and efficiency of the conventional healthcare system on the one hand and health-promoting activities aimed at improving lifestyle and other manageable social determinants of health on the other hand.[1]

This policy shift influenced the use of regional health authorities (RHAs). Beginning in the late 1980s, RHAs were instituted by most provinces as an instrument of policy reform and have been predominantly concerned with cost mitigation and healthcare system rationalization and integration (Boychuk, 2009). Though RHAs played a role in advancing health promotion, the literature indicates this was never a primary goal of regionalization thus regions' accomplishments along this path are less clear (Boychuk, 2009).

This uncertain role of regions in health-promoting activity was accompanied by the adoption of a variety of provincial strategies. Some provinces addressed the non-medical

[1] The term *health-promoting activities* and *social determinants of health* are discussed in detail in Chapter 2 as

determinants of health by establishing RHAs with responsibilities for both public health and the conventional healthcare system (Marchildon, 2006). Others regionalized the administration of the healthcare system while leaving public health centralized at the provincial level (Boychuk, 2009). In the province of Ontario, a third approach saw parallel systems operate with separate regionalized governance for public health and a combination of local and regional governance for healthcare (Ontario, 2007).

Regional health authorities represent a major transformation in healthcare decision-making aimed at both the allocation of health resources and local engagement. However, with an unclear understanding of how regional health authorities advance the health-promoting aspects of policy reform, it is uncertain whether Canadian health regions have reached their potential as agents of positive health system reform. As a next step in exploring such potential, this dissertation examines current relationships between RHAs and health-promoting activity.

This opening chapter outlines the purpose, goals and objectives of the research and introduces the context for exploring the linkages to and potential of regional health authorities in Canada. The discussion then turns to specific research questions regarding the relationships between regions and health-promoting activity. Assessment of the dissertation's contributions to research follows. Then, an overarching philosophical framework outlines the underpinnings of the research. A final section of this chapter presents the organization of the dissertation.

1.1 Research Problem and Questions

The purpose of the dissertation is to better understand the relationships between health system regionalization and health-promoting activity in context of Canadian health

policy. Although tautological, the underlying rationale for better understanding these relationships is that health regions should promote the health of those served yet, as observed above, the accomplishments are unclear.

Three research questions are of specific concern: 1. What is the nature of the relationship between regionalization and health-promoting activity? 2. Given the Canadian experience, how has regionalization enhanced or impeded health-promoting activity? 3. How do existing theories help in understanding regionalization and, more importantly, the relationships between place and health? Further, how does the understanding of these relationships reveal theory regarding regionalization and health-promoting activity?

To begin with the first question addressing the nature of the relationship between regionalization and health-promoting activity, it is useful to explore the current pattern of regionalization in Canada. A critical review of the literature on the historical development of regionalization in Canada as well as important theoretical approaches to regionalization and decentralization provide the context and foundations for understanding the relationships being studied. This review of the literature develops both a temporal and functional understanding of regionalization and sets the stage for questioning whether there is a stronger role for regions in promoting population health.

The second research question moves beyond the premise of the first question to examine the features of regionalization that enhance or impede health and health promotion. For example, rhetoric and literature repeatedly suggest that regionalization facilitates increased involvement by citizens in the planning and operation of healthcare (Mills, 1990; Ontario Ministry of Health, 2006; Rondinelli, 1980). It is argued that the

closer the involvement of citizens is in the planning and operation of local health services, the more likely it is that the focus will include health-promoting activities rather than solely on the conventional *doctors and hospitals* healthcare (Laverack & Labonte, 2000; Nutbeam, 1998). How these propositions have surfaced in the Canadian regionalization experience is addressed in a review of the historical development of regionalization.

An unpacking of literature on health promotion, social determinants of health, therapeutic landscapes and social justice provides context for this second question. This includes reflections on how health and place are connected at a regional level by the concepts of therapeutic landscapes and social determinants of health. The geographic concept of scale, as well as local decision-making autonomy, are similarly developed and considered to be important elements in setting an overall context for the empirical research (Nutbeam & Wise, 2009).

With this background, addressing the second research question involves an empirical study with detailed interviews with senior management involved in the leadership and governance of regional health authorities or local health networks in two provinces (British Columbia and Ontario). Intentionally the two provinces have contrasting policy around regionalization. A grounded theory methodology is used in the qualitative analysis of data drawn from the interviews and corporate documents of the RHAs. Grounded theory methods "consist of systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories 'grounded' in the data themselves" (Charmaz, 2006, p. 2). A constructivist grounded theory method is used in this research that acknowledges the active role of the researcher's experience and

perceptions in the collection and interpretation of the data (Bryant, 2014; Charmaz, 2006). Full details of the research design are outlined in Chapter 3.

The third question addresses the research at a theoretical level to consider a more in-depth understanding of the relationships between health system regionalization and health-promoting actions. This leads to a better theoretical understanding of regionalization and other concepts that connect place and health such as the social determinants of health and therapeutic landscapes (those places that are seen to contribute to health and well-being). Exploring this line of inquiry along with the insights garnered from addressing the first two questions leads to a theory of therapeutic regions. This theory does not implicate a RHA should only focus on health-promoting activities rather it envisages an aligned set of goals that produce quality results in both preventative and curative outcomes.

1.2 Contributions of the Research

This research contributes to the academic concept of therapeutic landscapes as developed within health geography, and to the development, understanding and evaluation of provincial health policy concerning health systems regionalization. This research adds to the application of the therapeutic landscapes concept at a regional scale and provides insights into how administratively defined jurisdictions facilitate the health and healing of individuals and populations. In doing so it contributes to the ongoing maturation of the conceptual framework of therapeutic landscapes as observed by Williams (2007) and Sternberg (2009).

This research also has specific, applied value. RHA policy development has been focused on cost mitigation and service integration and less so on advancing up-stream

health-promoting activities. Regionalization was quickly deployed in many provinces as the key strategy to address the policy priority of rationalization (Boychuk, 2009). In the past 10 years, RHAs in several provinces have been either rationalized or eliminated, which has led to ongoing reorganization and turmoil (Marchildon, 2006; Picard, 2008). This research considers the function of regions and aims to explore whether decision makers could develop a lasting beneficial health-promoting role for regionalization.

1.3 Conceptual Framework

Frankford (1994) asserts that much of the academic literature on health service research and health regionalization in Canada is atheoretical. Atheoretical work focuses on action and policy, applied studies, methodology and description and often gives limited attention to explaining or understanding the processes involved. Its primary focus is on the praxis of concepts rather than advancing theory. It is believed that incorporating theory into the discussion on health system regionalization can help in understanding the processes at work that shape the observed and recorded phenomena. According to Frankford, this stems from the historically close association between positivist perspectives and the pragmatic medical-administrative framework that permeates medicine, healthcare and allied fields. While post-positivist epistemologies characterized by Feyerabend (1975) and Kuhn (1962) have led to a major shift in the philosophical perspectives in health services research, there are those who suggest a resurgence of a positivist stance with the adoption of evidence-based research and practice, particularly in medically-oriented contributions to the field (Goldenberg, 2006; Walsh & Gillett, 2011).

Theory is viewed in this paper in the manner that Castree (2006) summarized much of Harvey's work. For Harvey, theory's power to diagnose or explain comes from its utility to help us discern "order out of apparent confusion; realities that are hidden from view; and, the ties that bind the apparently disassociated" (p. 255). Several existing theories that will be dealt with in reasonable depth in the following chapters are: local autonomy, territoriality and social justice. These theories provide insights into aspects of regionalization and are helpful in contextualizing the research findings; however, individually each falls short of providing a framework for this research, as their purposes differ in scale and scope.

An overarching perspective that has utility here is offered by structuration theory. Giddens' (1984) structuration theory argues, "…in the social sciences, all explanations will involve at least implicit reference to both the purposive, reasoning behaviour of agents, and the intersection of these with constraining and enabling features of the social and material contexts of that behaviour" (p. 179). In this way, structuration theory balances the duality of agency and structure. The theory suggests that relationships between the agency of individuals (actors) and structures of society are iterative and reflexive both being shaped by and shaping each other (Giddens, 1984). Structures are seen as the rules and systems for allocating resources and institutions within social systems in space and time (p. 17).

Since the 1980s, there has been frequent reference within sociology and human geography to the utility of structuration theory. Within the field of human geography, structuration theory is used in health geography by Dyck and Kearns (2006) and in Curtis' *Health and Inequality* (2004). In those works, the theory is cited as a helpful

framework because of the concept of iterative interactions between structure and agency that recognizes the interconnections observed in the study of space and place and health. Curtis (2004) elaborates these interactions by specific mention of Giddens' interest in time-space geography and a focus on everyday social practices of individuals, including interactions with the social determinants of health that iteratively shape the health of individuals and maintain and shape the social structures (p. 55).

Applying structuration theory to empirical work was never an intention of Giddens as he viewed it more as a counterpoint, that is a theory to generate discussion. Some attempts at applying structuration directly have led to challenges that frequently end up in frustration (Gregson, 1987) and resignation to the view that although structuration is an appealing theoretical framework, it is less clear how it can be applied. Such conclusions characterize "structuration as providing 'sensitizing concepts' for informing research, rather than a set of concepts to be applied" (Dyck & Kearns, 2006, p. 92). Other authors refer to the theory as an organizing principle (Curtis, 2004; Johnston & Sidaway) that guides research. This dissertation uses structuration theory as an overarching framework that sensitizes understanding and analysis.

The theory development contemplated in the third research question will build upon the insights offered by the first two research questions. Grounded theory emphasizes a theory building process based on the ideas and relationships *grounded* in the findings from addressing those questions (Charmaz, 2006). In addition, ongoing review of a wide range of literature is an important aspect of developing an emergent theory (Eisenhardt, 1989; Morse, 2003). Particular attention to the examination of literature that conflicts with any emergent theory helps promote "a more creative, frame-

breaking mode of thinking than (one) might otherwise be able to achieve" (Eisenhardt, 1989, p. 544).

1.4 Organization of the Dissertation

This dissertation has five additional chapters. The next chapter first presents literature on the development of RHAs in Canada since their *modern* deployment in the 1980s as well as theoretical and conceptual literature that helped shape provincial approaches to regionalization. Chapter 2 also develops the context for health-promoting activities by providing a critical review of literature on therapeutic landscapes, health promotion/public health and social justice. Chapter 3 details the research design and methodology, describes the case RHAs and the sampling process that led to the selection of key informant interviews. In this chapter there is full discussion how the data were collected, coded then analyzed and revealed as themes. Chapters 4 and 5 report the research findings from the thematic and interpretive data analysis. Chapter 6 discusses the research findings and presents conclusions including implications for RHA policy and practice. This closing chapter also outlines perceived limitations to this research and offers suggestions for future research and theory.

Chapter 2: Regionalization and Health-promoting Activity

This chapter develops the context for addressing the research questions by reviewing literature on regionalization and health-promoting activity. The opening sections focus on regionalization first by presenting and discussing core concepts of decentralization that have been influential in Canadian regionalization. There is an overview of recent Canadian health policy reform followed by a brief history of regional health authority development in Canada. This history of *modern* regionalization is framed in terms of two phases[2]. The first began in the 1980s and was hallmarked by an active period of regional decentralization in most provinces. The second phase involved (re)consolidation in most provinces that led, for the most part, to the patterns observed today. It is pointed out in the discussion that Ontario's experience with regionalization followed a different course during this time period. A final section of this first part of the chapter offers a critical review of themes presented in the literature of Canadian regionalization that are considered to be important to this research. They are: cost efficiency and system rationalization; region and province relationships; and citizen participation. This opening part on regionalization ends with an overall comment on the timing and quality of the literature itself before introducing the second part of this chapter that turns to the context for health-promoting activity.

The second part of the chapter (beginning in section 2.2) reviews literature that helps define health-promoting activity drawing upon determinants of health concepts. Also, there is a discussion on the theoretical and practical aspects of implementing

[2] The reasons for the use of the term *modern* are detailed at the beginning of the section of the history of regionalization (section 2.1.1).

health-promoting policy. This is followed by an outline of the geographic concept of *therapeutic landscapes* as a useful background and contributing piece for the context of this research. A discussion of literature on social justice and its application to health reform follows. The final section of the chapter offers an overall summary and conclusions regarding the context for the research questions and methodology.

2.1 Decentralization and Regionalization in Health Systems

Mills (1990) provides a framework for the decentralization of health services that was developed as part of a global review of regionalization practices for the World Health Organization. She relies heavily on work first published by Rondinelli (1980) that looked at government decentralization adopted in developing countries, particularly East Africa. Rondinelli (1980) proposed three types of decentralization: *de-concentration*, *devolution* and *delegation*. Mills (1990) added *privatization* as a fourth type of decentralization because that approach holds relevance and application to healthcare.

The framework of decentralization developed by Rondinelli (1980) and adapted by Mills found considerable favour in the literature on health services regionalization in Canada. Rondinelli's framework is outlined in detail by Mills (1990) for her global perspective; and it appears in British health services literature (Atkinson, 1995) and much of the Canadian literature (including, Bhatia and Dibert 1993; CMA Working Group 1993; Lomas, 1997). These three Canadian articles are widely referenced on the topic in Canada and, as such, Rondinelli can be considered to be highly influential in the development of Canadian regionalization policy.

De-concentration refers to a system that transfers some administrative authority to local offices of a central authority or government (Mills, 1990, p. 16). The key notion of

de-concentration is that the administrative authority may be moved away from the central authority, but the responsibility and the ability to withdraw or recall the decentralized authority remains with the central authority. Rondinelli's observation is that this type of decentralization is most common in developing countries, often with the aim of improving administrative efficiency. In these cases, Rondinelli insightfully comments the emphasis is on efficiency, that is, "putting one person in overall authority may actually be viewed as a device to promote centralized power rather than decentralization" (p. 17).

Devolution involves creating or strengthening local authorities or government that are mostly functionally independent (p. 19). The local authorities have separate and clear legal status, geographic boundaries, specific functions and statutory powers. Under a devolution model of decentralization, the local authorities usually have more control over what happens locally.

Delegation transfers certain functions to an organization that is outside of the central authority or government, yet the ultimate responsibility still remains with the central authority. The difference between this approach and devolution revolves around the nature of the autonomy from the central authority. Devolved authorities are usually more autonomous, often with separate governance structures. Whereas delegated authorities are still seen as part of the central authority, those with delegated responsibilities are seen as independent parastatal organizations (p. 22).

Privatization involves decentralizing government functions to organizations that would not operate within government regulation or guidelines other than those

established for the operation of private corporations. This approach to decentralization creates the least effective control over centralized standards or quality outcomes (p. 23).

Bossert (1998) cites Rondinelli's well-known approach as one of four overarching frameworks that address problems of decentralization in healthcare.[3] Because of the lack of specificity around which tasks and how much authority are best assigned to each level, Bossert does not prefer Rondinelli's *public administration approach. Local fiscal choice* and the *social capital approach* are two other frameworks that he considers before suggesting the *principal-agent* approach as "likely to be the most effective overall approach to decentralization" (p. 1517).

A principal-agent framework provides several channels of control (incentives, sanctions and monitoring information) available to the principal to facilitate decentralization to local authorities (agents). To this basic notion, Bossert adds the concept of *decision space* that represents the range of choices that would be available for local authorities. The *decision space* for financial matters may be differentially decentralized from that related to hiring or for purchasing or contracting.

Mitchell and Bossert (2010) apply this decision space framework to the experience of six countries (Bolivia, Chile, India, Pakistan, Philippines and Uganda) and conclude that a balance between centralized and decentralized decision space as well as better mechanisms of accountability are needed for improved health system performance. The authors differentiate between a typical governance perspective of accountability that they describe as a directional accountability (or accountability to whom) and a health systems

[3] Bossert (1998) refers to the Rondinelli framework as a public administration approach because of its focus on "the distribution of authority and responsibility for health services with a national, political and administrative structure" (p. 1515).

perspective of accountability described as object accountability (or accountability for what). They conclude that it is "difficult to make *a priori* statements about what form of decentralization is 'best' or 'strongest'- or what kind of accountability needs to be emphasized – since it depends on which combination results in better health" (p.687). Mitchell and Bossert assert that object accountability provides for common ground between a governance and health systems perspective.

Earlier work by Clark (1984) proposes how local decision-making relates to other orders of government in his theory of local autonomy. His basic four-element typology encapsulates inter-governmental relationships based on the concepts of immunity and initiative. Immunity is the power of a locality to function free of control and oversight from a higher order locality. Initiative, in this instance, refers to the ability of the locality to regulate or influence the behaviour of its residents.

It is notable that Clark's theory of local autonomy is developed from the interaction of the authority with the residents or the fundamental level of public engagement. This grassroots orientation differs from top-down delegation or devolution, which is the usual framework for Canadian regionalization (Bhatia & Dibert, 1993; Rondinelli, 1980). Giving power to local authorities is one of the concepts that shape the analysis of health system regionalization and its relationship with health-promoting activity. The relevance of the theory of local autonomy to this work is similar to that of Bossert (1998) in its emphasis on the freedom and ability of the local authority to make decisions.

Further insight into the mechanisms of local authority emerges from juxtaposition with the theory of human territoriality as proposed by Sack (1983). Territoriality is defined as an "attempt by an individual or group to influence, affect or control objects,

people and relationships by delimiting and asserting control over a geographic area" (p. 56). Sack sees that all territoriality is "socially or humanly constructed whereas, physical distance is not" (p. 57). In parsing the nature of territoriality, Sack details ten tendencies that can cause the controlling concept to exist. Three of these - classification, communication, and enforcing control - are considered necessary conditions for territoriality.

Sack sees territoriality as expressing power and influence with the effort needed for supervision: the greater the territoriality, the less need for supervision and supervisors, e.g., the rigorous territoriality of a prison requires fewer supervisors to guard convicts than would be needed if they were not confined (p. 69). This positive relationship between territoriality and span of control suggests that as territoriality increases so too does the need for greater span of control or alternative substations such as differing contact or skill.

In work that benefits from Sack's theory (Murphy, 1991) and in critical assessment of his work (Agnew & Duncan, 1989), there is confirmation of the basic premise that territoriality reifies space and develops a degree of control that is suggestive of the needed degree of oversight. However, both articles are skeptical of the predominant top-down structure of territoriality with little agency by those controlled. The value of this observation to this inquiry is in the fundamental connection between the definition of a territory and the implicit relationship between control and influence, which is of importance when considering a regional health authority's ability to move toward health-promoting actions.

These theories also reinforce each other and help in understanding the degree of agency that regions possess, aspects of control of central structures that form regions and the duality that reinforces both. The theories cover a wide range of possible explanations of the nature of regional relationships, and each has merit in shaping questions and interpreting data. At the same time, the theories fit together with the philosophical framework of structuration theory which can be viewed as bringing together a bottom-up local autonomy view and a top-down control-based, territorial view.

The theories offer insight into characterization of regions offered by geographers that is helpful to understand in framing the context for this work. They also highlight a fundamental paradox that accompanies regionalization schemes. When a central authority adopts a decentralization or regionalization approach that distributes authority from the centre to the region, it usually brings with it a centralization of authority from the local to the region. Decentralization of authority to health regions also usually means a reduction in local autonomy. This is highlighted in a following section of this chapter in a discussion of the regionalization experience of local boards in various provinces.

In sum, it is not essential to choose which theory is best suited here because hypotheses are not being formed or tested for acceptance or refutation. Instead, the relationships inherent in regionalization and health promotion may be said to be complex enough to benefit from theoretical pluralism even if they sometimes appear paradoxical and contradict one another.

2.1.1 A Brief Overview of Canadian Health Policy Reform

Regionalization refers to a planned and provincially legislated reform of the healthcare system when certain authority from the province is transferred to an

organization with responsibilities for health/healthcare in a prescribed geographic region. It was generally a policy response to the perceived need for rationalization of healthcare services that had developed in Canada over the last half of the 20th century (Marchildon, 2006). This section analyses these developments, relying upon several scholarly works that focus on the detail of jurisdictional and financial changes during this time period (Boychuk 2009; Marchildon 2006; Mhatre & Deber,1992; Ostry 2006).

From the end of WWII to about 1970, with rapid population growth and the advent of medicare, the Canadian healthcare system experienced significant expansion in terms of funding, facilities and services. The hallmark of this period was the introduction and expansion of publicly funded health insurance. After Saskatchewan started with a provincial health insurance plan for its residents in the 1940s, several other provinces did as well (Ostry, 2006). Federal legislation was in place in the late 1950s to provide cost sharing to build and maintain provincial health systems and was made more comprehensive in 1966 with the passing of the Medical Care Act. In 1977, federal funding (per capita, not cost sharing) for health was bundled into comprehensive funding for social programs. Under criticisms of lack of transparency in funding allocations for health and of extra billing practices of physicians, the government responded with the Canada Health Act (passed in 1984), adding clarity and conditions to federal funding (Marchildon, 2005; Ostry, 2006).

The Established Programs Financing Act (1977) and The Canada Health Act (1984) also represented a general retreat from federal influence over provincial health and welfare services in that changes resulted in a smaller proportion of total health spending being supported by the federal funding. This allowed the provinces more flexibility in

allocating program funding across components of healthcare (Boychuk, 2009). Yet clearly outlined immutable conditions for federal funding were put in place. Healthcare was to be provided according to the five principles of universality, comprehensiveness, accessibility, portability and public administration that needed to be upheld or provinces would risk funding reductions (Boychuk, 2009).

Debates about health system sustainability carried on for several decades. During the 1970s, concerns over funding responsibility and the sustainability of the healthcare system resurfaced when the federal Minister of Health, Marc Lalonde, published a landmark report, *A New Perspective On The Health Of Canadians (1974)*. This report introduced the concept that the conventional healthcare system was but one of four *health fields* or determinants influencing the health of Canadians (Laframboise, 1973; Lalonde, 1974).[4] Lifestyle, environment and human biology were the other main determinants. While not assigning relative weights to each health determinant, Lalonde asserted that there is:

> ... no doubt that the traditional view of equating the level of health in Canada with the availability of physicians and hospitals is inadequate ... there is little doubt that future improvements in the level of health of Canadians lie mainly in improving the environment, moderating self-imposed risks and adding to our knowledge of human biology. (p. 18)

There have been several retrospective reviews of the impact of the Lalonde report (Buck, 1985; Chenoy & McQueen, 1985; Hancock, 1982, 1986). One point of consensus is that there was better reception internationally for the Lalonde report than there was in Canada, where policy changed slowly. The slow reaction in this country appears to hold

[4] Laframboise was the principal author of the Lalonde report while serving as the Director General of the Long Term Health Planning Branch of Health and Welfare, Canada. His article *Health policy: breaking the problem down into more manageable segments* was published in the Canadian Medical Journal the year before the Lalonde report was tabled.

significance for the work of this dissertation. The first reason for the slow take-up was that the messages of Lalonde were interpreted in Canada as a framework to move away from or to rationalize the conventional healthcare model, more than to move toward the other determinants, particularly those of health promotion (self-imposed risks) and environment. The report did not offer a road map on how to make adjustments to rebalance health policy (Boychuk, 2009; Hancock, 1986). Second, the health promotion message, framed in Lalonde as moderating self-imposed risk, was criticized and resisted for being tantamount to blaming the victim (Hancock, 1986).

Such criticism and message shaping had the effect of dampening the message of health-promoting activity (Terris, 1984). As an example, the presentation and the subsequent reception of the Lalonde report has been described as a "vague critique of Canadian healthcare" (Boychuk, 2009, p. 358). One result of this resistance was that the broad acceptance of Lalonde's message only came years later with the publication of a federal report from a subsequent Minister of Health, Jake Epp, entitled, *Achieving Health For All* (Health and Welfare, 1986) and with the near simultaneous adoption of the World Health Organization's Ottawa Charter for Health Promotion (WHO, 1986).

Achieving health for all (Health and Welfare, Canada, 1986) implicitly shifted the scale of health concerns from the provincial to local level. Whereas healthcare in Canada is clearly a provincial responsibility, the health promotion framework presented by Epp was one that underscored the importance of locally led initiatives. It called for "self-help" and "mutual aid" and the creation of healthy environments at "...home, school, work or wherever else [Canadians] may be. It means communities and regions working together to create environments which are conducive to health" (p. 9).

Similarly, the strategies of the Epp Report called for public participation focused on community groups and support for strengthening community health services, with communities being "more involved in planning their own services" (p. 10-11). While Epp's health promotion framework reinforced Lalonde's message that the path to health for Canadians involved multiple determinants and was not exclusively reliant upon doctors and hospitals, it also stressed two new messages. First, that many health-promoting influences such as education and housing are related to the social structures of society. Second, often differences in these determinants manifest at a local or community level. The relevance of these messages is that they raised questions about the relationship between the level at which health is determined, and the level or scale at which health is most regularly managed and administered.

The policy climate at this time was also influenced by the relationships between the emerging concept of determinants of health and conventional government roles. Lalonde (1974) pointed out explicit jurisdictional responsibilities for the four influential determinants:

> The health field concept disregards questions of jurisdiction ... human biology, environment and life-style are national in character and ... problems in these areas tended to pervade Canada's population with little regard for provincial boundaries ... In short, the first three elements of the health field concept are open to federal initiatives in addition to those which are already underway. (p. 64)

In a policy climate widely influenced by Lalonde and Epp, a predominant message was one of "therapeutic skepticism" as to the efficacy of the traditional health system comprised of doctors and hospitals (Boychuk, 2009).

By the mid to late 1980s, the policy environment began supporting a *determinants of health* approach to improve population health increasingly based on a view of the

healthcare system as fragmented, narrowly focused on doctors and hospitals and a provincial responsibility. At the same time, provinces were motivated to cutting costs because of the difficult financial situation resulting from a recession in the early 1980s (Ostry, 2006). In response, most provinces undertook a critical review of their health policies and considered new strategies for cost reduction and reform. A number of studies and reports on the reform of provincial health systems soon followed (Marchildon, 2005; Mhatre & Deber, 1992). These reports emphasized common objectives: the need to reduce the costs of healthcare delivery; the need to shift from a solely curative agenda; and the preference for integration of providers, services and systems (Marchildon, 2005). Regionalization was an implementation strategy promoted in every province. However as Mhatre and Deber (1992) noted, there remained differing opinions as to how regionalization should proceed:

> All the provincial reports recommended the development of regional [health] authorities. However, there is some variation in how much power they believed should be devolved. The reports differed in their recommendations on how the proposed regional authorities should be funded, on membership and appointment to boards, on the range of services offered, and the responsibilities of both the regional authority and the provincial government. (p. 658)

In summary, health policy in Canada can generally be characterized as organized around a bifurcated approach. On one hand policy aims to provide an affordable quality healthcare system with services to meet a wide range of need. On the other hand are the messages from Lalonde, Epp and the Ottawa Charter that individual and population health are determined by more than just healthcare; that there are other fields that require action on a broad range of determinants. While there is a direct link between policy aimed at addressing the rising health systems costs and regionalization, there is uncertainty around the role regionalization has played, or should play, in helping advance

the health promotion branch of policy. Adding to this uncertain role has been the variety of approaches by the provinces to both regionalization and public health as is evident from a review of the historical development of RHAs in Canada.

2.1.2 Historical Development of Regional Health Authorities (RHAs) in Canada

The history of decentralized health regions in Canada is long and varied. Saskatchewan gained early experience in 1944 when regions were established for the planning and delivery of healthcare to a sparsely distributed and mostly rural population (Marchildon, 2005). Ontario also had a long history with regionalization of portions of its health system as public health units were first established in 1882 with responsibilities for public health only.

Such early regionalization experiences represent meaningful stories on their own. However, those undertakings fall outside of the temporal and functional scope of a regional health authority, which is the focus of this work. In this dissertation, concern is with the *modern* regionalization policy reforms that a few provinces began to implement in the 1970s, even though their greatest uptake came later as part of health system policy reform in the late 1980s and 1990s. There are two reasons for this attention to *modern* regionalization in this research. One is that the timing coincides with the overall health policy shift discussed above to a bifurcated policy environment focused on both conventional healthcare and health promotion. The other reason is that the current patterns and nature of regionalization have been mostly influenced by the provincial actions over the past 25 to 30 years.

Table 2.1 outlines the year modern regionalization was implemented in each of the provinces. There are key insights offered by the chart. It reveals the establishment of

Table 2.1. Modern (after 1980) Health Service Regionalization in Canada

Province	Year regions established	Restructured	Nature of Changes
Newfoundland and Labrador	1994	-	Four health and community service boards.
Prince Edward Island	1993	2002	No regions. Prior to 2002 there were 4 Regional Health Authorities (RHA).
New Brunswick	1992	2002/2008	Currently seven zones, changed from 8 RHAs in 2008 and changes in board structure in 2002.
Nova Scotia	1996	2001	Nine RHAs preceded by four.
Quebec	1989-1992	2001/2003	There were 18 RHAs. Now 7 with broader roles.
Ontario	2006	-	14 Local Health Integration Networks (LHIN). Ministry of Health said a review would be conducted in 2012 but no public results as yet.
Manitoba	1978/1998	2012	Latest change in 2012 saw a reduction from 11 to 5 RHAs.
Saskatchewan	1992	2002	Reduced from 32 health districts to 13 RHAs.
Alberta	1994	2002/2003/ 2005/2008	There is one 'region' that operates with five zones. Prior to 2008 there were 9 RHAs reduced from 17 set previously. Also changes as to how board members were put in place and at one point included some elected board positions.
British Columbia	1993/1997	2001	Currently five RHAs (containing 16 Health Service Delivery Areas) and 1 provincial health service. There have been two restructurings. Prior to the current configuration there were 11 regional health boards, 34 community health councils and 7 community health service societies.

Source: adapted from Lewis and Kouri, 2004.

regions in nine provinces during the 1990s. This coincides with the beginning of a period of significant contraction with the hospital sector in Canada (Ostry, 2006).

A first phase of modern regionalization is characterized by the experience in Saskatchewan in the early 1990s when a comprehensive system of 15 RHAs replaced the boards and rationalized governance of over "400 hospitals, long-term care home, home-care service agencies and ambulance organizations …" (Marchildon, 2005, p. 37). Government reports at the time saw that "…local community health services [needed] to be rationalized within a larger geographic area as a result of the shift in population from rural to urban areas, and the need to change the mix of services to meet the health needs of the older population remaining in the rural areas …" (p. 37). Additionally, the financial situation in the province was desperate. When the Romanow government took power in 1991, it moved quickly in implementing recommendations toward regionalization based on the shifting demographics, cost pressures and hopes that the new strategy would help resolve both problems (p. 38).

In Saskatchewan, these actions fused the concepts of regionalization, restructuring and cost pressures together into a single reform concept in the minds of health planners and analysts in Canada. Most other provinces faced similar financial pressures and also considered restructuring necessary, thus regionalization was usually part of the strategy to move forward (Mhatre & Deber, 1992).

A few provinces had implemented regional planning with less aggressive approaches, yet the dramatic change in Saskatchewan and its link to funding pressures

and regional realignment represented a new era in regionalization (Mhatre & Deber, 1992).

Alberta rejected the notion of RHAs when they were first introduced in Saskatchewan. In two short years, however, with a new leader in government and mounting financial pressure, the Klein government in Alberta reversed its decision and implemented regionalization in 1993 (Church & Smith, 2008). In a detailed assessment of the Alberta experience, Church and Smith (2008) point out that a regionalization policy idea had been developing within the Ministry of Health as a way to break down the silos in healthcare delivery in the province; yet "…as a policy idea emanating from the public service, regionalization was a political non-starter, until it became tied to the larger fiscal reform agenda" (p.230).

This establishes a link between regionalization as a strategy within the wider political agenda. The Alberta government had decided to act aggressively on its financial problems of the early 1990s. There was perceived resistance to change by many stakeholders in healthcare. Regionalization allowed the issue of reform in health to be wrapped within the larger matter of fiscal responsibility. Regionalization advanced only because it was viewed as an answer to the rising costs of healthcare.

In this first phase, regionalization was seen as the policy fix for cost mitigation and rationalization of services in the health care system (Boychuk, 2009; Marchildon, 2005). During this period, the relationships between the RHAs and the province typified by provinces retaining key authorities, such as appointing chairpersons, CEOs, approving RHA budgets and requesting detailed regional health plans (Lomas, 1997). Lomas (1997) offers that the only meaningful difference among regions across Canada in terms

of regionalization was the scope of authority that provincial legislation provided to RHAs.

Table 2.1 indicates that most provinces significantly adjusted the nature of their RHA system. A second phase of regionalization emerged around 2000, and it continued for more than ten years and can be largely identified as [re]consolidation.

The adjustments ranged from procedural, such as changes as to whether directors should be elected or appointed, to boundary changes (Lewis & Kouri, 2004). There were a few larger scale changes such as Saskatchewan reducing thirty-two districts to thirteen authorities, and British Columbia introducing a two-tier approach to regionalization, which included both regions and districts.

Because regionalization was so closely tied to cost reduction, it was inevitable that the costs of the regions themselves would come under scrutiny. In Alberta, the number of RHAs was reduced and reworked four times in the early 2000s until there were none. PEI also eliminated RHAs. New Brunswick and Manitoba reduced the number of regions and offered political reasons: equal access, uniformity and the desire to eliminate unhealthy competition for resources (Manitoba, 2012; New Brunswick, 2008). In these cases, consolidation was related to concerns over the increased cost of regionalized management or related to a perceived need to realign the scope of regional services. Other observers indicated that the changes were a matter of correcting the balance of control between the central and local authorities (Picard, 2008).

The development of regional health authorities in British Columbia followed somewhat of a different path in that its first plan called for a two tier local system of regions, in addition to the province maintaining its role over some services. The Seaton

Commission produced its *Closer to Home* report in 1991 including regionalization as one of the ways to improve health care delivery in the province (British Columbia, 1991). Shortly thereafter in 1993 the government embraced the regionalization idea in its *New Directions for a Healthy British Columbia* plan and it took action to create and transfer authority to 20 regional health boards and 82 community health councils accountable to the regional health boards (British Columbia, 1993). By 1996, this first regionalization structure was considered to be duplicative and costly (British Columbia, 1996). In response, the Ministry of Health adopted a new plan for regionalization that resulted in 11 regional health boards (mostly urban), 34 community health councils and 7 community health service societies (mostly rural), each with its own board and management team. British Columbia further overhauled its (British Columbia, 1996) regionalization scheme by reducing both the number of regions and eliminating the existing hierarchy of local regional authorities (British Columbia, 1996; Marchildon, 2005). In 2001, the BC government transformed its system again to encompass five regional health authorities and one provincial authority for coordinated programs such as cancer care. Like most provinces undertaking regionalization, this move was seen to bring benefits of improved efficiency, improved health system planning and health system coordination (Marchildon, 2005).

Regardless of their nature, these adjustments, reinforced the relationships between costs and restructuring through regionalization. Even with these adjustments, any meaningful difference among regions in most provinces remained the scope of service that had been decentralized to regions by their provincial Ministry of Health (Lomas, 1997).

While these two phases of regionalization characterize a common pattern that occurred in most provinces, Ontario was notable in its unique, and gradual approach. In Canada's largest province, the means of addressing health system cost pressures and restructuring regionalization was different than in others. In the mid-1990s, Ontario's Progressive Conservative government undertook significant reform without regionalization legislation by empowering a Restructuring Commission to assess opportunities for hospital and long-term care facility integration. It also proceeded with an overhaul of community-based care (Sinclair et al, 2005). These actions reduced provincial per capita total health expenditures and per capita hospital expenditures (Marchildon, 2006).

For decades before this restructuring, regionalization partially existed in Ontario with Public Health Units and regional health planning units called District Health Councils. Both were mandated with specific roles in the health system and were governed by local boards. Then in 2005, Ontario announced and began planning for a regionalization scheme to establish Local Health Integration Networks (LHINs). These became corporate entities in 2006, and began operation in April 2007 (Ontario Ministry of Health, 2007).

Ontario's fourteen LHINs are distinguishable by their mandate. Each has funding accountability and focuses on planning, encouraging and directing health system integration. It is important to note that the span of services under the direction of the LHINs does not include public health or the over two hundred hospital boards in the province. The Ontario Public Hospitals Act remains in place giving local hospital boards

governance authority and accountability for most of the local aspects of the conventional health system.

The Ministry of Health for Ontario outlines the role of LHINs as:

> …not-for-profit corporations that work with local health providers and community members to determine the health service priorities of their regions. LHINs are responsible for planning, funding and managing health services in their communities. … LHINs don't provide services directly; instead they are responsible for integrating services in each of their specific geographic areas. Through community engagement, LHINs work with local health providers and community members to develop integrated health service plans for their communities. (Ontario Ministry of Health, 2014)

Many important aspects of the healthcare system continued to be centrally controlled by the province including physician services, contract bargaining with most hospital nurses, cancer care services, capital project approvals, overall operating budget approval, as well as human resource decisions e.g., LHIN board chair and initial LHIN CEO selections (Ontario Ministry of Health, 2007).

Overall, the Ontario approach is distinct and difficult to evaluate given its recent and gradual implementation (Marchildon, 2006). Regionalization left local governance in place for hospitals and long-term care and assigned a planning, funding and integration mandate to the LHINs. This approach to governance is seen as an attempt to balance the local and central authority that is a challenge in other jurisdictions.

The Ontario approach continues to evolve. It first involved regionalized planning with a focus on integration among the numerous health service providers. Then the LHINs were assigned a role in allocating funding from a centrally controlled budget. Ontario has talked of a full review of the LHIN approach; yet this has not as yet been completed. (Matthews, personal conversation, 2011). In December 2015 a discussion

paper was released that invited comment from Ontarians on options for future development of LHINs (Ontario, 2015). Importantly this discussion paper and the accompanying legislation calls for LHINs to take over service delivery responsibilities for the Ontario network of Community Care Access Centres (CCAC) that provide community and home care and coordinate access to long term care facilities. The report also calls for expansion the role of LHINs in primary care funding. The introduction and development of regionalization has unfolded at a measured pace with a strong central role exerted by the province.

Statistics Canada periodically publishes a review of regional health authorities in Canada. Its most recent update in 2013 reported that there were 87 regional health authorities across eight provinces, with Alberta having no regions, but rather five administrative zones, and with only Prince Edward Island reporting one provincial level of organization (Table 2.2). Reorganization in Manitoba in 2012 resulted in a reduction from eleven to five RHAs and is the only recent change reported by Statistics Canada. There has been stability to the regionalization schemes in Canada for the past several years. It is uncertain whether this stability in RHA structure reflects a more mainstream role for RHAs, a phase as other priorities dominate the health care agenda, or whether a new mandate and/or vision for regions will influence the current pattern in the future.

Table 2.2 Summary of Changes in Canadian Health Regions 2011-2013

Province	Health Region	Number of units 2011	Number of units 2013
Newfoundland and Labrador	Regional Integrated Health Authorities (RIHA)	4	4
Prince Edward Island	Health Regions	1	1
	Zones	6	6
Nova Scotia	District Health Authorities	9	9
New Brunswick	Zones	7	7
Quebec	Régions sociosanitaires	7	7
Ontario	Local Health Integration Networks (LHIN)	14	14
Manitoba	Regional Health Authorities	11	5
Saskatchewan	Regional Health Authorities	13	13
Alberta	Zones	5	5
British Columbia	Regional Health Authorities (RHA)	5	5
	Health Service Delivery Areas	16	16
Yukon	Territory	1	1
Northwest Territories	Territory	1	1
Nunavut	Territory	1	1

Source: Statistics Canada, 2013 http://www12.statcan.gc.ca/health-sante

2.1.3 Themes within the Regionalization Literature

Most of the literature on regionalization was published in the late 1990s and early 2000s, with little new information emerging in recent years. This was noted when Black and Fierlbeck (2006) commented that:

> ... the literature on regionalization has diminished considerably in the past five years, even as the policy itself has become commonplace. While policy-makers and policy analysts have more experience at this point with which to evaluate

> regionalization, there is less literature on the policy now than when it was first being implemented. Part of the problem is that it is a complicated, unwieldy, and frequently contradictory concept, even in the theoretical realm. When applied to practical policy-making, the variables which influence any determination of how well regionalization works become even more complex. Yet it is precisely the fusion of policy and politics which should make regionalization such a fascinating case study. (p. 507)

Since that observation in 2006, the volume of literature remains limited. Part of the reason for the continued lack of attention to regionalization is likely related to the changing perspective of regionalization as a policy reform. Most of the early literature concerning Canadian healthcare regionalization originated from health services administration and policy experts. In the 1990s and into the 2000s, regionalization was a major part of health reform. Now that regions have existed in some provinces for decades, they are no longer a reform of the healthcare system. After their introduction and the association between regionalization and rationalization, RHAs are now an accepted part of the healthcare structure and are studied less often.[5]

The analyses and critiques that emerged in the academic literature were aimed at both a national and provincial scale (Boychuk, 2009; Church & Barker, 1998; Lewis & Kouri, 2004; Lomas, 1997; Marchildon, 2005a).[6] Three themes that were common in the research of the national scene include: cost efficiency and system rationalization; the nature of the relationships between region and province; and questions about citizen

[5] A reduction in the literature is not the only indicator that research enthusiasm about regional health authorities and regionalization has changed. Regionalization has generally faded from professional conference agendas. Furthermore, the Canadian Centre for Analysis of Regionalization and Health was defunct in 2005 when short-lived federal funding was withdrawn.

[6] The referenced articles take a national view of regionalization. There are others whose focus is localized including: Church & Smith (2008) and Hinnings et al., (2003) who looked at reform in Alberta; Black & Fierlbeck (2006) in Nova Scotia; Reamy (1995) in New Brunswick; Neville et al., (2005) in Newfoundland.

participation. Each of these is discussed below followed by a summation and conclusion of this part of the literature.

2.1.3.1 Cost Efficiency and System Rationalization

The expectation that regionalization was associated with attaining system cost efficiencies was commonly observed and commented on throughout the literature (Black & Fierlbeck, 2006; Church & Smith, 2008; Hinnings et al, 2003; Hurley, 2004; Lewis & Kouri, 2004; Lomas, 1997; Marchildon, 2005; Neville et al, 2005). Shorter term financial benefits were seen by most of the authors to be attributable to a region's better ability to align resources to population health needs through opportunities for horizontal and vertical integration of services at the local level and the realization of economies of scale in healthcare administration (Boychuk, 2009; Lewis & Kouri, 2004). Longer term efficiencies were expected to emerge from a shift toward health promotion as well as through better integration among sectors, such as, acute care, long term and community based care – in effect, creating a continuum or system of care (Boychuk, 2009).

The literature was clear that most of the claims of cost efficiency were based on limited empirical evidence. Church and Barker (1998) criticized the prospects of attaining economies of scale from regionalization in Alberta because of the extra requirements for detailed and enhanced information needs as well as the difficulties of contracting costs from relatively small regional operations. They also argued that by transferring many, but not all, costs (physician services and drug expenditures were excluded) it would be difficult for either the region or the province to control total costs. Ultimately, they forecast that costs would actually increase and that regionalization would "likely fall well short of expectations" (p. 482).

Other skepticism was evident over the cost efficiency claims of regionalization. Black and Fierlbeck (2006) noted that in New Brunswick the contraction of thirty-six hospital boards into four regional boards, and then the [re-] expansion into nine regional boards over a five year period (1996-2001) were "justified by the explicit references to cost containment and greater accountability, even though the first took numerous units and amalgamated them, while the second took few units and multiplied them" (p. 506).

In the literature, regionalization is clearly associated with provincial responses to policy reform and with addressing inefficient and fractured healthcare systems. Whether regionalization was necessary to achieve cost efficiencies or whether it was just more loosely involved as a catalyst for rationalization is debatable. Fuelling one side of the debate is the Ontario situation in which major rationalization of the conventional healthcare system was undertaken before regionalization. This suggests that other provinces' reforms may have viewed the role of the region to be akin to that of a standard-bearer in the struggle to rationalize excessive service provision and to control healthcare costs.

2.1.3.2 Region and Province Relationships

With responsibility for healthcare being primarily a provincial responsibility, it is no surprise that there is no one model for RHAs in Canada. Each province has developed its own legislation and implementation strategy. For example, regions in some provinces have more scope of service and authority over spending than others. Many provinces appoint regional board members, including their chairpeople as is detailed in governing

legislation (Lewis & Kouri, 2004; Lomas, 1997; Marchildon, 2005).[7] While it is common for RHAs to enter into annual contracts with the province to define regional service priorities, the only constant across the provinces is their desire to maintain control and influence over regional actions (Marchildon, 2005). Regionalization in the 1990s involved "devolution of authority [that] was less than meets the eye" (Kouri & Louis, 2004, p. 22). This view supports the contention that regions were not the driving force of healthcare system rationalization.

Fyke, who led a major health reform review in Saskatchewan, commented on the relationship between region and province:

> Regionalization is only a structure. All too often it has been a structure without a mission. How could it hope to succeed? Structure must be designed to achieve a strategy that includes a clear mission or purpose. In addition, effective reform requires that the strategy and structure be supported by appropriate culture and skills. Too many governments have made the structure an end onto itself (Change Foundation, 2008).

This lack of a clear purpose has also been manifested in terms of changes to regional approaches (Lewis & Kouri, 2004). As pointed out earlier, several provinces have changed boundaries, numbers and size of regional health authorities over time. As well, several articles report that board appointments, service or accountability agreements and reporting structures resulted in considerable instability for a decade or more (Church & Barker, 1998; Lewis & Kouri, 2004; Marchildon, 2005).[8]

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[7] At the outset of regionalization, there were approaches that included direct elections for board members. Half of the board members in Saskatchewan were elected. This practice ended when the Province moved to larger regions (2002) and elections had experienced poor turnout (Marchildon, 2005). The unaddressed question is whether the decision to remove elected board members was also influenced by Lomas' observation that the accountability of elected board members to their constituents could counteract provincial direction and provider concerns.

[8] As pointed out in the first chapter, the rate and type of change in RHA organization has subsided over recent years.

The models of regionalization are devised and implemented by the provinces in a medico-administrative paradigm that contains a highly structural philosophical underpinning with little, if any, recognition of the population served. Evidence for this perspective is two fold. First, each province has imposed one legislative framework and model for its health regions whether the regions are serving metropolitan areas or rural districts. While the demographic and health needs vary across such different territories (Kulig & Williams, 2012), the regional approaches within provinces do not vary. Second, there is little mention of practitioners, patients or society and there is less agency attributed to providers or users who comprise the system, whether central or local, or whether exercising authority or being cared for (Benoit, 2002). Frankford (1994) supports this philosophical challenge and sees the structural and positivist approach as one of the major shortcomings of health services research, the field that comprises much of the writing on regionalization and reform. He argues, "because biomedicine and health services research share positivist epistemic and methodological premises, both objectify the subjects they study, abstract those subjects from context and thereby ignore the cultural dimensions of the problems at hand" (p.773). His view calls for new research on the nature of regions and their relationships, such as that developed here.

2.1.3.3 Citizen Participation

On the issue of citizen participation, the literature observes that the rhetoric has clearly been stronger than the results (Black & Fierlbeck, 2006; Frankish et al, 2002). Notably, there was considerable government rhetoric about how increased citizen participation would be helpful in regions advancing more effective systems. However, as Frankish et al. (2002) argue, there has been little progress as to how to develop

meaningful citizen participation. More concerning, they also argue there is a lack of empirical evidence about how such participation leads to effective healthcare system outcomes reflected within the rhetoric.

Labonte (1990) warns that citizen participation is often promoted for reasons other than improved health outcomes. He suggests that a romantic view of community involvement is one reason for the rhetoric of participation. Another motivation for citizen involvement is to offset an organization's reduced effectiveness because of its bureaucratization. Third, Labonte suggests that a certain degree of mistrust of the ability of professional staff to adequately reflect citizens' needs encourages external processes of citizen participation.

Labonte's mention of bureaucratization is a summary process for what can be characterized as a stripping away of local autonomy. When local boards governed healthcare they were individuals from the local community with a certain degree of autonomy to ensure the local programs and priorities reflected current needs (Marchildon, 2006). With the advent of regional boards, the ability to emphasize specific local priorities was at best watered down as boards were now populated with a different type of individual: one often appointed by the province or by a board that had a regional perspective (Lewis & Kouri, 2004).

Furthermore, there are frequent disconnects between the scale of *local* community participation and the regional, provincial and national economic and social policies that are most often the basis of citizen engaged discussion (Labonte, 1990). It is evident that to be meaningful, citizen participation must move beyond tokenism (Arnstein, 1969). Considerable energy and money is spent engaging citizens and methods such as

participatory action research have evolved to improve the effectiveness of end user perspectives. The results of such engagements however, suggest meaningful participation is difficult partially because of the episodic nature most people have with healthcare (Frankish et all, 2002, Labonte, 1990, Marchildon, 2005).

2.1.3.4 Summary

In summary, the literature reviewed above highlights three themes that were prevalent when regionalization was implemented in Canada – cost efficiency, region to province relationships and citizen participation. Together, these three themes characterize regionalization as a reform initiative led by a changing Canadian health policy paradigm, with a focus on rationalization. During this period, regions were treated only as structures without sufficient clarity around role or mission (Change Foundation, 2008; Lewis & Kouri, 2004).

Of note is the absence of recurring themes in the reviewed literature that address the relationship between regionalization and aspects of social justice, health equality/equity or the relationships with a neoliberal approach to government in many provinces. The reasons behind these omissions are not the purpose of the analysis here but it does suggest there are many outstanding questions that would likely provide productive avenues for future research.

As noted above, the momentum and nature of further changes to regionalization are uncertain. It seems evident regionalization policy no longer stresses the relationship between cost pressures and restructuring. Black and Fierlbeck (2006) conclude that in Nova Scotia, there is a question as to the ability of regionalization to address cost pressures. In fact, they note, "… it is difficult to distinguish savings garnered from cost

efficiencies (of regionalization) from those achieved through simple budget cuts" (p. 523). The authors find that the underlying political environment has had more influence over the current nature of regionalization than any other factor.

These changes would appear to reflect more than descriptive observations of the evolution of regionalization. It can be argued that they represent the renewal of the concept of regionalization, one that is freed from the cloak of restructuring. Church and Smith (2008) recount that the strategy of regionalization to facilitate more integrative healthcare was emerging in Alberta in the early 1990s and only moved from a "bureaucratic idea with no legs to a policy solution" when associated with the larger reform agenda (p. 233). Now that the relationships between cost containment and regionalization appear to be weakening, there may be opportunities to explore regionalization as a strategy for other objectives of health system reform including improved health promotion and access to care.

Over twenty-five years ago, Rosenberg (1988) posited that the models and methodologies used by medical geographers for analyzing healthcare delivery systems had reached an intellectual cul-de-sac. His argument was that the models and methodologies did not link to the socio-cultural and political-economic influences in the environment (p. 181). In spite of advances by medical geographers to embrace a more comprehensive perspective on healthcare delivery, much of the discussion has stalled and as expected in a cul-de-sac, which leads to circular arguments and little forward progress. Rosenberg concluded that to "further intellectual development of the analysis of healthcare delivery systems, medical geographers must find new frameworks that link the geographical, the medical and the political in healthcare delivery systems" (p.185).

In a more recent treatment of these issues, Rosenberg (2014, 2016) assesses progress and themes in health geography (an expansion of the former label of medical geography - see work by Hayes [2000] and by Kearns & Moon [2002] for example). He observes how familiar themes of access to care, neighbourhood health studies and environmental health continue to dominate research and he raises questions around theoretical (e.g., idealist theory) and concerns around methodological approaches that are influencing current research. Arguably, the only implicit indication that the cul-de-sac concerning healthcare delivery has been reshaped (but not transformed), surfaces from the implicit observation that research has moved beyond conventional healthcare delivery issues to embrace broader concerns about the nature of health and well-being.

Regionalization could also be said to be in an intellectual cul-de-sac of its own. It has been noted that the literature on regionalization has become scarce (Black & Fierlbeck, 2006). This is happening at a time when the experiences and models of regionalization in provincial systems are transforming the way care is provided. Regionalization is no longer viewed as the principal agent of system rationalization. Fundamental concerns regarding RHAs' sustainability, local autonomy and improvements to health and healthcare are now topics that need to be explored in order to better understand how regions can contribute to both paths of Canadian health policy. A new framework is needed and understanding the relationship between regionalization and health-promoting activity may provide insights into that framework.

2.2 Health-promoting Activity and Social Determinants of Health

An understanding of health-promoting activities originates from the earlier characterization of a bifurcated health policy that strives to develop and reform the

conventional medical healthcare system and, at the same time, improve conditions and outcomes of the non-medical determinants of health. The concept of health-promoting activity broadly refers to actions aimed at health promotion and disease prevention, often led by public health professionals (Detels, 2009). In much of the literature such activity is referred to public health, which Detels (2009) defines as "The biologic, physical and mental well-being of all members of society regardless of gender, wealth, ethnicity, sexual orientation, country, or political views" (p. 3). Evans and Stoddart (1994) underscore that most health-promoting activities are aimed at contributing to health, while avoiding those activities that are harmful in a forward-looking manner. They see conventional, curative healthcare as more reactive and responsive to "perceived departures from health" (p. 27).

Gulliford (2009) comments that early advocacy for health-promoting activities was accompanied by the view that conventional health services did not aim to improve overall population health. He points out that it is now widely accepted that disregarding conventional healthcare is an untenable argument and that the two branches of policy should not lead to an oppositional relationship as if it were a zero-sum-game (p. 252). Evans and Stoddart (1994) observe that the embrace of a health-promotion perspective does not "justify devaluing" the curative care or, what some refer to as, the sickness system (p.28). In the end, the common outcome for both health policy paths is to improve the health status of those served; the difference is in the content and process of moving toward that outcome (Gulliford, 2009; Holland, 2009). However, the early questioning of the contributions of various approaches by Lalonde (1974), Health and Welfare Canada (1986) and Wilkinson and Marmot (1998) directed research to focus on

the outcomes and efficacy of health interventions. Arguably, the quest for evidence-based outcomes was most evident in the realm of public health, health-promoting activity and the body of work under the rubric of social determinants of health (Detels, 2009; Gulliford, 2009; Raphael, 2006; WHO, 2008).

The concept of social determinants of health emerged in the analysis of the mid-1800s analysis of structural connections between political, economic and social forces that threatened health (Raphael, 2006). While that early work remained outside the "mainstream of current discourse on determinants of health in North America and other nations such as Australia and New Zealand", these early works were instrumental in re-focusing attention from the medical and healthcare causes of poor health to the *causes of the causes* of poor health (p. 652).

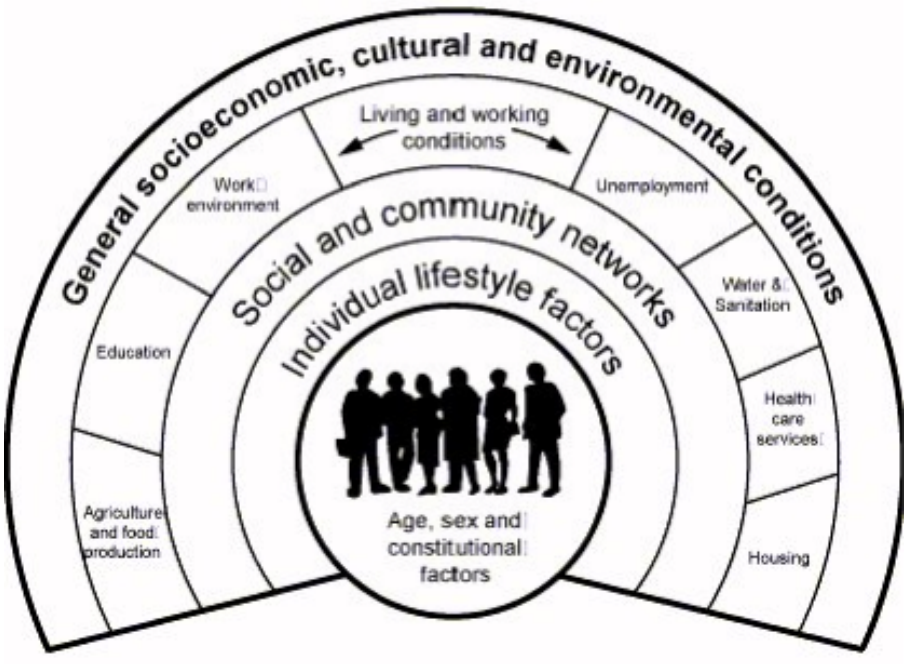
The social determinants of health are entwined with the view that health includes physical, social and emotional well-being, and is more than just the absence of disease (WHO, 2008). The concept of social determinants of health is now generally defined by those variations in social factors (such as social position, income, housing, education and employment) that influence the health of individuals and populations (Evans, Barer & Marmor, 1994; Marmot & Wilkinson, 1998; Raphael, 2006).

It is worthwhile to note that the model advanced by Evans and Stoddart (1990), and reproduced in *Why are some people healthy and others not?,* draws a connection between the determinants and population health. They do this through a discussion of public investment in health and healthcare. They go so far as to say that further investment in healthcare may not have positive effects upon the population's health. Specifically, they

argue “a society that spends so much on healthcare that it cannot or will not spend adequately on other health-enhancing activities may actually be reducing the health of its population” (p55). Critics think this view is driven by a deeper, less-evident population health agenda that has enabled some dismantling of publicly funded healthcare systems (Poland et al., 1998).

While the models of the social determinants of health cited above are situated within a belief that medical care is not the sole driver of human health, their conceptualizations of the importance and interplay of social forces vary. Common to most models is the notion of different categories of determinants that have been captured in a broadly referenced graphical model by Dahlgren and Whitehead (1991) (Figure 2.1).

Figure 2.1: Main Determinants of Health



Source: Dahlgren & Whitehead (1991)

At the centre of the Dahlgren and Whitehead model are the biological assets of individuals and populations such as age, gender and hereditary factors, over which individuals have least control. From this foundation, the Dahlgren and Whiteside graphic is presented as four radiating external rings of health determinants. The first ring beyond the centre reflects the biological/genetic and lifestyle factors that reflect the individual, and which influence the risk of disease or premature death. These factors are often narrowed down to smoking, alcohol consumption, diet and exercise, but can include other risk factors, such as stress. The second, third and fourth rings, respectively, include social and community influences; living and working conditions; and general socioeconomic, cultural, and environmental conditions. This layering of the influence of determinants is common in many models (Marmot & Wilkinson, 1998; Raphael, 2006).

Graham (2004) synthesizes various models of the social determinants of health and develops a simple heuristic framework with six components, each sequentially influencing the next. They include: social structure, social position, social/material environment, behavioural/physiological factors, illness and injury, and their social consequences. She explains the key components of the heuristic as follows:

> Like the models from which it derives, [this model] represents health as the outcome of causal processes that originate in the social structure, in which social position is embedded. Although the definitions vary, social position usually refers to an individual's location in the social hierarchies around which his or her society is built. Social position thus includes such dimensions as socio-economic position, gender and ethnicity. ... Social position marks the point in the model at which societal-level resources enter and affect the lives of individuals. (p. 107)

Many works associate the concepts of social determinants with, or make links to or between, policy developments. Raphael (2006) delivers a series of papers from a conference aimed at increasing dialogue around the determinants and outlining policy

directions for Canadian healthcare. That work outlines eleven social determinants of health, including: early childhood, education, employment and working conditions, food security, healthcare services, income and its distribution, housing shortages, social exclusion, social safety nets, unemployment and aboriginal status (p. 6).

The World Health Organization (WHO) published a second edition of *The solid facts*, a document aimed at informing policy makers about the social determinants (Wilkinson & Marmot, 2003). This publication was followed by an explanatory text that provided academic evidence for the model and its assertions (Marmot & Wilkinson, 2006). The determinants in this model vary from Raphael's in that housing, aboriginal status, education, income and healthcare services are not identified as separate determinants of health but others such as stress, addictions and access to transportation are included.

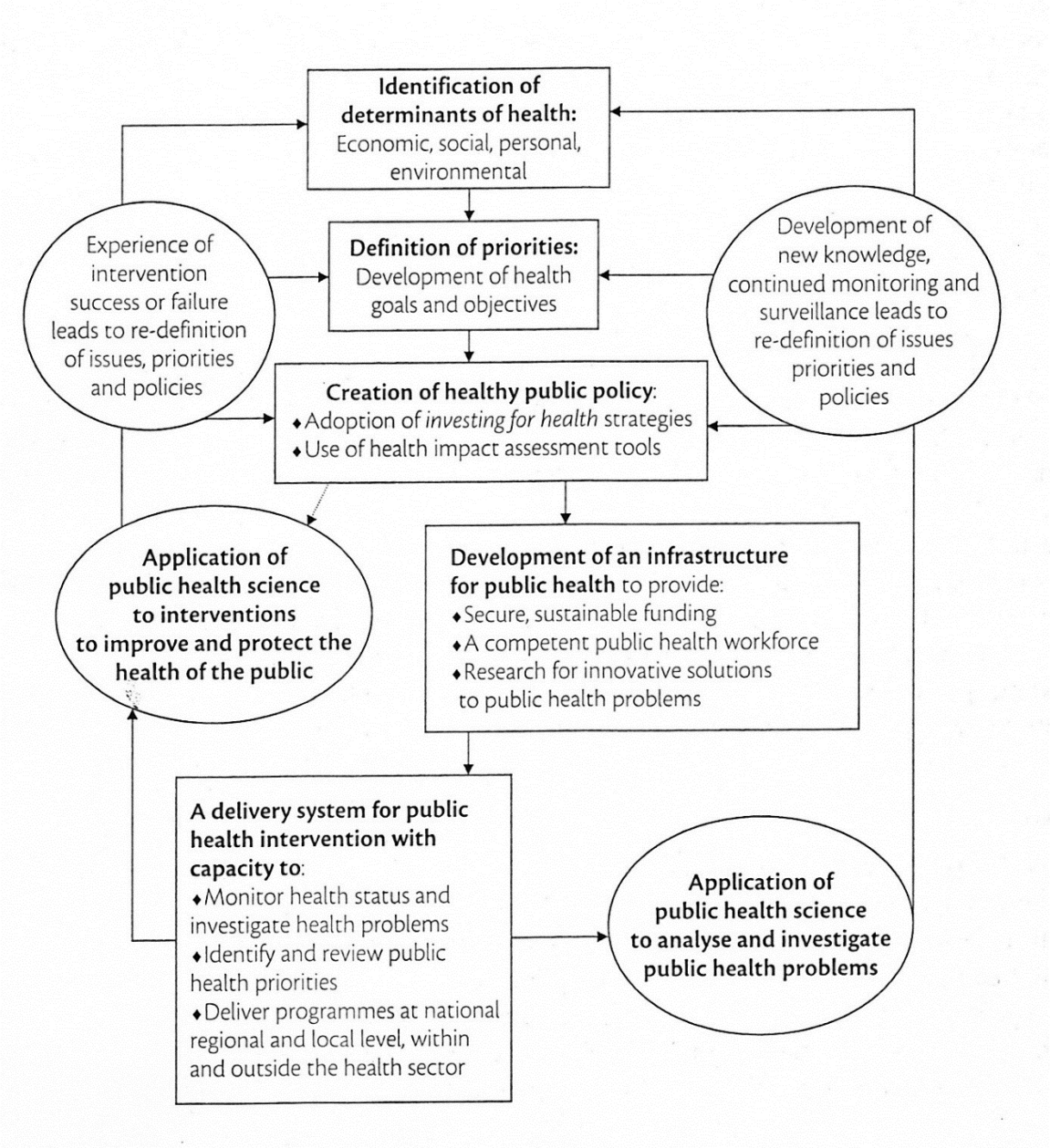
Differences among determinants in terms of priorities between nations can be expected at different times. Other literature, for example, provides the case for specific determinants to be considered, such as urban-rural lifestyles (Dixon &Welch, 2000). The actual determinants are important in each circumstance, but the prime concern is how they overlap and impinge on or influence the daily health of individuals. Finally, the concept of the social determinants of health suggests an interdisciplinary approach and is focussed on subject matter and empirical work that informs policy (Marmot, 2005; Marmot et al, 2008; Marmot & Wilkinson, 2006).

In 2008, the World Health Organization (WHO) reported on its Commission on Social Determinants of Health that had been established to "collect, collate, and

synthesize global evidence on the social determinants of health and their impact on health inequity, and to make recommendations for action to address that inequity" (WHO, 2008, p. v). Its principal message is that the relationships between the determinants and population health inequities are clear and it is time for governments to take action on the inequities and to "close the gap in a generation" (p. 1). Similar calls for action appear elsewhere in the literature. Nutbeam and Wise (2009) encourage public health professionals to move beyond studying the science of the social determinants and focus on the "application of the concepts' principles within the health sector and more broadly within society in ways that have an impact on the social determinants of health" (p. 1653).

The calls for a stronger renewed focus on implementation raise questions of how best to proceed. Nutbeam and Wise (2009) offer insights into the development of a model aimed at understanding the infrastructure needed for public health interventions (Figure 2.2). They emphasize developing the infrastructure and delivery systems to draw attention to critical aspects of implementation, such as organizational capacity and investment requirements, yet they generally leave the question of how best to intervene open, beyond saying that action should be "nationally relevant, locally sensitive and financially sound" (p. 1663). By strategizing without set priorities, the model falls short of addressing what it sets up as its fundamental question for moving forward (p. 1664). The more important point, however, is that it should be a priority to better understand the practical matters of infrastructure for successful public health interventions.

Figure 2.2: Overview of an Infrastructure for Public Health Intervention



Source: Nutbeam & Wise (2009)

Nutbeam et al. (2010) have also looked at questions of implementing health-promoting activity by reviewing and summarizing several theories or models that influence health promotion practice such as: diffusion of innovation theory (Rogers, 2003), a typology of community organization (Rothman, 1968), community building and empowerment (Minkler,1998; Rissel, 1994) and community capacity (Goodman et al. 2002; Bush, Dower and Mutch, 2002).

Nutbeam et al. (2010) analyse the theories on change in communities and stress the importance of local community involvement, empowerment and the development of the capacity to address factors influencing the health of its population. Similarly, these theories suggest that operational effectiveness models in health promotion call for organizations to be able to work with relevant, related sectors, such as income or social services, in ways that may require changes in fundamental internal actions, such as budget cycle, or decision making processes. Nutbeam et al. (2010) conclude that changes in communities and organizations are seen as vital ingredients of health-promoting activity implementation because a localized population health scale allows for local, community input.

The linking theme throughout these arguments on implementing action on the determinants of health and public health interventions is the emphasis on the importance of analysis at the community and regional levels. Nutbeam et al. (2010) emphasize the value of health-promoting action to involve community or regional level agency as opposed to any other scale, as this orientation facilitates understanding population health needs and enables a focus on social forces that determine health.

2.3 Therapeutic Landscapes

Working within the sub-discipline of health and medical geography in the early 1990s, Gesler (1992) introduced the concept of therapeutic landscapes.[9] Physical landscapes, both natural and human-made, were seen as fostering the therapeutic processes of healing and "…[thus] therapeutic landscapes become a geographic metaphor for aiding in the understanding of how the healing process works itself out in places (or in situations, locales, settings, milieus)" (p. 743). Further, the concept of landscape became a reflection of the history, culture and social relationships, not just the built structures or the geomorphology of a particular place (Kearns & Moon, 2002).

According to Williams (2007), the concept of therapeutic landscapes originally embraced traditional, natural and built landscapes, including beaches, spas and spiritual retreats with reputations for healing (e.g., Lourdes, France). Over time the concept has been extended to focus on marginalized populations and healthcare, especially hospital environments. She further observes that early critiques of the concepts of therapeutic landscapes led to the understanding that the relationships of individuals to landscapes can either be positive or detrimental. Several empirical studies have illustrated these opposing relationships (Kearns & Collins, 2000; Watkins & Jacoby 2007) and have further suggested that whether a particular landscape is therapeutic or not may vary by time and place. In summing up the variations of the therapeutics of place, Gesler (2005) notes that the concept is itself *context dependent* and may also vary among individuals.

[9] Gesler's full introduction of the concept in 1992 was preceded by his discussion of therapeutic landscapes in his book, *The cultural geography of health care* (1991).

Much of the literature on therapeutic landscapes appears to fall short in two important areas: one relates to the predominance of attention on individuals or geographically specific populations (as opposed to a broader inclusive perspective of population health); the other relates to an apparent lack of attention to the full nature of relationships between landscape and health.

A review of the literature helps with regard to the first area where the concept of therapeutic landscapes falls short and could be strengthened. For example, the majority of the collection of twenty-one articles in Williams (2007) relates to individual experiences or those of *special* populations including the isolated, marginal, or geographically specific populations. An exception is the article by Hoey (2007), who provides an extension of the therapeutic landscape concept in a way that addresses the role of community. In his work on a redeveloped asylum in northern Michigan, he refers to literature from psychiatry that develops the idea of a therapeutic *community* that "...derives from an almost entirely applied context. Encompassing place-based treatment and healing processes, it focuses attention specifically on important social relationships and the total milieu of social life (Jones, 1968; Kennard, 2004; Main, 1983)" (p. 300). In Hoey's (2007) view, the therapeutic relationship is conveyed not with just a single site but with all of those variegated physical and emotional spaces embraced in a community.

Hoey's (2007) treatment of therapeutic landscapes and communities is important since it moves the concept of therapeutic landscapes from a individual or group scale to a community wide relationship. Also, he defines his therapeutic community not just as physical space or social structures within a community but as "something that must be experienced. Because of varying individual perceptions, community, or perhaps 'sense

of community' may or may not be achieved through the intent of those who plan it" (p. 301). This broad view evokes the idea that a therapeutic community is a place that holds meaning for those who experience it (e.g., see Buttimer, 1998; Yi-Fu Tuan, 1974). With this framework, it is possible to see how regions and places created by administrative authorities, such as regional health authorities, guide the social, political and experiential realities that influence health. Accordingly, it is possible that administratively shaped landscapes could have the potential for being therapeutic regions. However, it is also clear that needing to experience a region is not typical in the current casting of RHAs.

The second area where the therapeutic landscape concept could be strengthened results from the nascent stage of its evolution. Most of the literature focuses on a relationship between landscape and health that is based on correlations and little understanding of the causal nature of the relationship. Again in Williams (2007) several articles cite retreat, solitude, relaxation as conditions related to therapeutic landscapes and there is only suggestion with little discussion of a meaningful cause and effect relationship (Collins and Kearns, 2007; Conradson, 2007; Gesler and Curtis, 2007).

This focus on correlation is akin to the early investigations of the social determinants of health, which focused on direct physical linkages such as substandard shelter and poor health (Marmot et al., 1994). At the time, the links between health and healing through other determinants, such as employment, were less clear. However, as research and discussion advanced, better understanding of causal links has developed (Marmot & Wilkinson, 2006). Medical practitioners have commented on the physiological linkage between social determinants and health, and it has been suggested that a similar link exists between therapeutic landscapes and health (Brunner & Marmot,

2006; Sternberg, 2007).

Brunner and Marmot (2006) focused on the connections between social organization, stress and health. The authors acknowledge that factors work at both the scale of the individual and beyond the individual (e.g., social organization). However, their model links "social structure to health and disease via material, psychosocial, and behavioural pathways" and raises the importance of stress as the linking pathway (p. 9). They suggest that regular disturbances of physiological equilibrium brought on by the repeated activation of the fight-or–flight (stress) response may lead to ill health and disease, particularly for those who may not have the social and individual capabilities for response. They proffer that "[i]t seems likely that the optimal stress response in relation to health in the long term is associated with living and working environments typical of the materially advantaged. This optimal response can be characterized as one with a rapid return to a resting level and, thus a high resistance to stress related disorder" (p. 27). They acknowledge that the evidence to date does not allow for unqualified statements about the causal role of stress from social disadvantage. They point out that more work into the relationships among stress, social organization and health is needed. In their concluding comments Brunner and Marmot (2006) provide their view that stress has on individuals in both the short and longer term:

> Stress has short-term effects on the human body and mind. The effects are positive if the situation is right, but everyone has his or her limits. We are now beginning to recognize that people's social and psychological circumstances can seriously damage their health in the long term. Chronic anxiety, insecurity, low self-esteem, social isolation, and lack of control over work appear to undermine mental and physical health (p. 28).

Writing as a family physician researcher, Sternberg (2009) builds upon the argument linking stress, landscape and health/healing. She posits that when a landscape, natural or built, has special meaning or comfort for an individual then stress is lessened and the potential for healing is increased (p. 37). Her use of an insightful analogy on the differences between a maze and a labyrinth brings a tangible spatial dimension to the effect of stress:

> Mazes have always been associated with fear and stress, from the time maze-like designs first appeared in Greece, around 320 to 140 B.C.E. – ... Actually, labyrinths and mazes have very different structures.
>
> Unlike a maze, with many choice points and many paths, a true labyrinth has only one path in and one path out. The one in leads to the center [sic], and the one out leads back to the starting point. There are no decisions to be made and no blind alleys, and, most important, you can see the path ahead. There is no reason to be vigilant – you simply follow the path. Unlike a maze, a labyrinth does not inspire fear or the stress response. It calms. (p. 103)

A maze of blind alleys and many choice points is a frequent and almost colloquial description of most provincial healthcare systems in Canada.

Curtis (2004) adds perspective to these relationships by pointing out that "...in geographical terms researchers think about spaces of risk: "combinations of health determinants coming together in different ways, resulting in variation in the risk to health for the population in places. Part of the role of health geography is to describe and explain these spaces of risk" (p. 6). Curtis' *spaces of risk* are abstract, relational and vary across day-to-day activity (social practice) space, hidden in most traditional representations of space and most frequently are manifested in regional pockets such as an inner city. Curtis carries her argument further by drawing upon important principles of social justice, which can be added to the conceptual framework that is taking shape

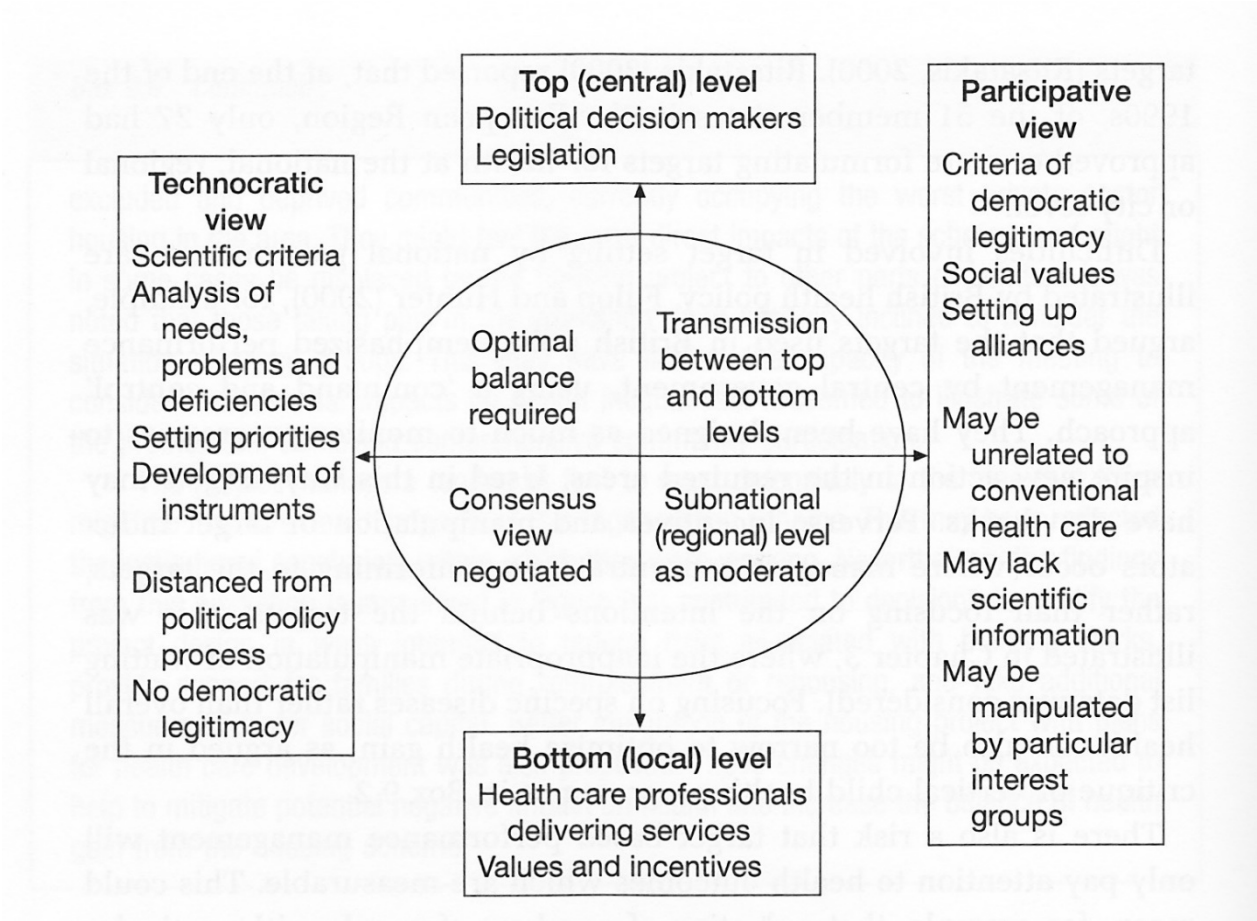
because spaces of risk often represent spaces of health inequality. Bonta and Cagle (2009) underscore this association when they link health equity to the public health objectives of reducing health disparities and assuring access for all to healthcare with the aphorism that "public health at its best is social justice" (p. 783).

2.4 Social Justice

Social justice is a complex concept that is often favoured by polemicists yet too often is left undefined. The concept of social justice in health has been embraced by several authors (Curtis, 2004; Daniels, 2008; Ruger, 2010) and referenced in major works on justice (Rawls, 1999; Sen, 2009). A review of this literature aims to unfold some of the complexities of the concepts of social justice and health. In particular, sections of Curtis' (2004) *Health and Inequality* are referenced to reveal how approaches to social justice can influence and be influenced by regional schemes. In doing so, a definition is embraced that is based on the Rawlsian precept that justice is fairness (Rawls, 1999).

Curtis (2004) discusses a model developed by Wismar and Busse (2000) in which successful decentralization of health services requires negotiation between two continuous dimensions (Figure 2.3). Along the vertical axis central and local authorities

Figure 2.3: The Political Coordinates of Health Target Programmes



Source: Curtis, 2004

are presented in opposition guided by their need to reach consensus. The same need for agreement applies to technocratic (evidence-based) and participative (community-based) interests, which are positioned perpendicularly on the horizontal axis of the model. With these opposing perspectives, Curtis sees a central role for regional authorities to negotiate effective social justice in health policy and fairness in health program resourcing. She observes:

> Finding the right balance between these different 'poles' will depend on negotiation at various geographic scales, and the preferred solution may vary locally from one area to another. This poses challenging questions concerning how social justice can be resolved 'universally' in framing health policy and allocating resources, for a country as a whole, and 'locally' respecting the need for equity and sensitivity to differences between different areas. Wismer and Busse (2000) suggested that this requires negotiation to reach a consensus and that a relatively independent regional level of government has a useful role in moderating between the central and the local level. (p.275)

Along with outlining a legitimate role for regional agency, these observations from Curtis frame the concept of social justice, which is central to both health reform and decentralization. Questions about social justice arise from the interaction between health inequality, which is regionally manifested, and the need for allocation of scarce resources (Daniels, 2008).

Rawls' *Theory of Justice revised edition* (1999) and Sen's *The Idea of Justice* (2009) are two weighty tomes that delve into questions of justice. Rawls' work, published in 1971, was seminal and ground-breaking. A Rawlsian view is that justice is fairness and that "each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all" (p. 266). His second principle asserts "social and economic inequalities should be arranged so they are … of the greatest benefit to the least advantaged" (p.266). This principle of justice suggests that a minimization of inequality and maximization of opportunity are both important to realizing social justice (p. 65).

Sen applauds Rawls' work, yet outlines several criticisms that evolved over the nearly four decades since Rawls first published. For example, Sen generally reflects a post-structural philosophical perspective and the need for both greater acknowledgement of individual action, as opposed to institutions; a need to move beyond a *contractarian*

view of justice (Rawls presented his original work as a development of Rousseau and Locke); and the need for a more global, as opposed to local/national perspective. Sen notably addressed these differences by moving from a macro-institutional to a micro-individual frame of reference. The conceptual bridges built by Sen reflect how the themes of justice and moral philosophy provide valuable frameworks for addressing interesting health system questions. Three such works that address health systems and social justice include: Daniels, in *Just Health Care* (1985) and *Just Health* (2008), and Ruger, in *Health and Social Justice* (2010).

Daniels' two books, written twenty-three years apart, reflect his personal growth in recognizing that population and individual health involve more than healthcare. By omitting the word *Care* from his second title, he revealed his new understanding of the social determinants of health. Daniels generally embraces Rawls' *justice as fairness* approach and its strong principle of fairness of opportunity. He addresses the fundamental question of "what do we owe each other to promote and protect health in a population and to assist people when they are ill or disabled?" (p. 11). His methodical approach to addressing this question leads to the fundamental discussion of health inequality, of resource constraint, and of what each owes to other individuals in society. In his latter section, he importantly argues that "the fact that we get an equal chance of being cured once ill because of equitable access to care does not compensate us for our unequal chances of becoming ill" (p. 142). Ultimately, Daniels talks about the utility of the *justice as fairness* approach to health. It is these sections that have direct relevance to questions of fairness in health sector reform. Specifically, how do we know if changes to system structure and organization (e.g., regionalization) are fair or just to the population

being served? This leads him to a discussion of work he produced with others in 1996, *Benchmarks of fairness for health care reform* (Daniels et al, 1996).

Daniels (2008) gathers insights from various healthcare systems including Canada as well as Scandinavian and European countries in order to investigate justice and healthcare reform in the United States of America (US). In doing so, he suggests setting benchmarks to facilitate the evaluation of health reforms. His ten benchmarks to consider for "fairness for national health care reform" include: 1. Universal access: coverage and participation; 2. Universal access: minimizing non-financial barriers; 3. Comprehensive and uniform benefits; 4. Equitable Financing: community-rated contributions; 5. Equitable Financing: ability to pay; 6. Value for money: clinical efficiency; 7. Value for money: financial efficiency; 8. Public accountability; 9. Comparability; and, 10. Degree of consumer choice.

Ruger's (2010) book, *Health and Social Justice* aligns closely with Sen's work on justice and is more focused on the particular social justice questions that were faced by the US health system at that time. Specifically she discusses the principles of justice and her concept of the 'health capacity paradigm' and its fourteen principles. Central concepts embedded in the principles relevant to this dissertation are that justice in health policy should be assessed in terms of health capabilities rather than health achievements alone, and equality in health policy should be measured in terms of shortfall equality – a comparison of the shortfalls between actual achievement and optimal average achievements (p. 112-116).

Ruger's paradigm offers guiding principles for health system reform rather than specific concrete actions. However, the principles could be helpful by suggesting a framework for analyzing various health regionalization reforms, especially, in the Canadian context, when provinces amend or revise strategy with little more than brief comments on the achievements or non-achievements, as has been the case in Manitoba and Alberta. Similarly, a social justice framework is a useful reference when RHAs make decisions on resource allocation and produce accountability reports, particularly around health-promoting activity for marginalized populations.

Social justice literature, particularly using Ruger's insights, supports a view that health care reform can be thought of as evolving along a continuum. The outcomes and achievements ranging from one with little health-promoting outcomes to one with major advances in reducing shortfall equality in terms of quality of life and life expectancy.

2.5 Summary and Conclusions

Several areas of literature have been considered to reflect the context for this research. The material reviewed indicates that *modern* regionalization is closely connected to rationalization whereas its role in advancing health-promoting activity appears limited. Regionalization also represents a shift in how healthcare is governed. In many provinces when regionalization was first instituted it tended to strip away autonomy from local communities, vesting it in regional authorities that were often closely influenced by the provinces. In this way, it reflects a decentralized model with limited effort toward true devolution of authority. Further, it is important to note that regionalization has not been static. After initial inception, (re)consolidation has occurred in many provinces. As well, Ontario has not followed the path as most other provinces; it

charted its own path of regionalization that has kept extant local hospital board and local public health boards in place.

Health-promoting activity includes a broad spectrum of actions from individual lifestyle decisions to major population health interventions. It has been pointed out that citizen (population) engagement at the local or regional scale is helpful to implementing health-promoting activity (Nutbeam & Wise, 2009). In fact, there are several ways that local or regional scale of activity can support health-promoting activities including developing local programs around specific needs.

Two broad concepts were highlighted in this chapter. The geographic concept of therapeutic landscapes offers a framework for understanding the relationships between regionalization and health-promoting activity. Places, including health regions, can support health and healing. It can be argued that occurs by therapeutic places reducing stress in individuals. Finally, the concept of social justice supports an understanding that health policy reform often justly evolves on a continuum that reflects what health reform can accomplish (health capability) not solely what has been done (Ruger, 2010).

In sum, the literature suggests that regionalization, health-promoting activity, and concepts of therapeutic landscapes and social justice are interwoven around common themes related to the quality and timing of health interventions: both curative and health-promoting. Through these interconnections, they set the stage for addressing the research questions for this dissertation regarding the relationships between regionalization and health-promoting activity.

Chapter 3: Research Methodology and Methods

Developing a research design is not completely a matter of free choice. Decisions on how to proceed are shaped by the philosophical approach to the research; the questions that are posed; and on the background and perceptions of the researcher (Creswell, 2007). The chapter starts with a discussion of how structuration theory and the philosophical underpinnings of hermeneutics provide context for the research and led to a qualitative study and, in particular, a constructivist grounded theory method. The remainder of this chapter turns attention to the application of Grounded Theory Method (GTM) to the empirical work that was conducted for this dissertation. This includes a section on critical reflexivity to the personal influences of the researcher and the details around the collection and interpretation of data from corporate documents and key informant interviews.

3.1 Structuration Theory, Hermeneutics and Qualitative Methods

In the opening chapter structuration theory (Giddens, 1984) is explained and is positioned as a useful sensitizing approach for investigating the central questions of this research. The iterative and dynamic nature inherent in structuration theory helps frame this study of the relationships between the regional health authorities and provincial departments around health-promoting agendas. This can be seen with provincial direction that outlines the structure, territory and scope of services for RHAs, yet the implementation of the statutory framework involves agency by the RHA with periodic policy, strategic and other types of service planning, annual budgeting and various programmatic interaction (NH, 2014; NWWLIN, 2014). A RHA's actions influence, in

turn, the priorities and directions from the province. All of these processes are dynamic and iterative involving interaction among the province, RHA, community and other health providers. Understanding how these relationships manifest in different provinces is useful in developing further insight into RHAs and health-promoting activity.

Proceeding with structuration as a lens and with an objective of *understanding* relationships also reinforces a naturalistic qualitative inquiry. This is in contrast to an investigative stance that seeks causal explanation. At the outset of this research there were no *a priori* hypotheses as to the nature of the relationships under study. As the inquiry unfolded, improved understanding of relationships surfaced from critiques of a broad range of related literature, review of RHA corporate documents, and focussed key informant interviews.

This research is situated in the post-positivist philosophical approach of hermeneutics, which is aimed at understanding and interpretation, and has been defined as "the art of interpretation as transformation" (Ferraris, 1996). Hermeneutics began as an interpretation of religious texts and expanded into "an ongoing process of interpretation" (Brinkmann et al., 2014, p. 21). As the philosophical stance of hermeneutics was developed, the differentiation between quantitative and qualitative inquiry was similarly dichotomized. To illustrate this point, Brinkmann et al. (2014) cite:

> Dilthey developed a descriptive psychology, an approach to understanding human life that was fundamentally different from how the natural sciences work. We explain nature through scientific activity, Dilthey said, but we have to understand human cultural and historical life. A life, as the hermeneutic philosopher Paul Ricoeur said a century after Dilthey, "is no more than a biological phenomenon as long as it has not been interpreted." (Ricoeur, 1991, p 28)

Kinsella (2006) ascribes five characteristics to the classic hermeneutic approach which: 1. seeks understanding; 2. acknowledges the role of the researcher in interpretation of data; 3. recognizes the role of language in interpretation; 4. views inquiry as a conversation in that there is an inherent back and forth between data and those involved with interpretation; and, 5. is comfortable with ambiguity by "…[recognizing] the uniquely situated nature, historically and linguistically [and geographically], and the ambiguous nature of interpretation, and offers such for readers to engage with, or not, as they wish" (p. 9). Importantly, Kinsella (2006) also outlines the concept of 'critical hermeneutics' that involves both an element of inquiring suspicion, which in social sciences often implies a focus on "social structures of inequality" (White, 2004, p. 317), and an approach that "searches for a way between dualities" (Kinsella, 2006, p. 12).

Qualitative research is situated within the hermeneutic tradition. It allows for a deeper understanding of the nature of relationships between phenomena (Bradshaw & Stratford, 2010; Cloke et al, 2004). Creswell (2007) identifies a social constructivist paradigm as a worldview that characterizes qualitative research as being aimed at:

> (White, 2004)[the qualitative researchers'] understanding of the world in which they live and work. They develop subjective meanings of their experiences – meanings directed toward certain objects or things. These meanings are varied and multiple, leading the researcher to look for the complexity of views rather than narrow meanings into a few categories or ideas. The goal of research, then, is to rely as much as possible on the participants' views of the situation." (p. 20)

Grounded theory method offers a qualitative method that is appropriate for this research because it outlines a process for qualitative data analysis and it facilitates the development of theory. GTM is a research method, first developed in the late 1960s,

which permits the researcher to develop a general explanation, or theory, of interactions that are grounded in the data and that are shaped by the views of the research participants (Bryant, 2009; Charmaz, 2006; Glaser & Strauss, 1967). Bryant (2009) sensibly articulates the difference between GTM as the research method and the outcome of the research method that is usually referred to as grounded theory.

3.2 Grounded Theory Method

Glaser and Strauss (1967) developed GTM to examine specific social problems and the process around them in a fashion that would "construct abstract theoretical explanations of social processes" (Charmaz, 2006, p. 5). Their fundamental GTM proposition was "its emphasis on research founded directly on gathered data, rather than initial hypotheses, offered a route whereby researchers could aim to produce novel theoretical insights in the form of substantive theories …" (Bryant, 2014, p. 119). At the time they were working, much academic work was conducted within a positivist philosophical frame and focused on deductive research that tested hypotheses mostly developed to strengthen existing theories. GTM offered a way of building theory from the data; specifying that theories need not be the starting point, but could be the outcome of research. Bryant (2014) expresses it this way:

> This is not to suggest that the later viewpoint [GTM] eclipse the former, but rather that the sequence of "theory then hypotheses then research" can be supplemented or replaced by the sequence "research then theory and hypotheses" (p. 119).

GTM "consists of systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories 'grounded' in the data themselves" (Charmaz, 2006, p. 2). In its early applications, GTM was not without its critics. In its early adoption it was seen as being prescriptive or deterministic in its requirements for data processing,

including open and axial coding of data, usually collected through interviews, and focused on core categories or phenomena (Creswell, 2007). The method seemed to only emphasize data gathering, which "mysteriously led to the "emergence" of some end result" (Bryant, 2014, p. 124). The value of this early criticism is that it has resulted in refinements to GTM that provide alternative stances and flexibility to the coding regimen while still working to maintain analytical rigor.

In seminal work on GTM by Charmaz (2002; 2006), she posits a modified GTM within what she calls a *constructivist GTM* approach. This approach is one that "had to take account of the active role of the researcher in moving to preliminary data collection through analysis and to coding, then iterating through further stages of collection, analysis and coding. Thus, codes and categories did not "emerge" but were the product of deliberate interpretation by the researcher(s)" (p. 124). Creswell (2007) expands this sentiment by noting the constructivist GTM allows for a shared role between the individual researcher's perspectives and the method of research.

Charmaz (2006) considers grounded theory method an approach that is flexible with guidelines not rules. In this vein she offers a process for constructing grounded theory, which includes: 1. Gathering data; 2. Coding data: initially to begin the conceptualization of your ideas and subsequently to allow synthesizing the ideas; 3. Consolidating concepts through writing and analyzing (frequently referred to as memo-writing); 4. Iterative reassessing and evaluating data gathering with additional sampling, if needed, and assessing data saturation; 5. Developing theory. In presenting this research process, Charmaz affirms that the grounded theory outcome of the constructivist GTM "offers an interpretive portrayal of the studied world, not an exact picture of it" (p. 10).

The inquiry in this dissertation is well suited to a constructivist GTM because the interest is in developing a better understanding of the relationships between RHAs and health-promoting activities. RHAs are organizations with front line influence on the health of Canadians yet arguably with uncertain accomplishment to relationships in regards to advancing the health-promoting policy direction. The interest here is in developing theory that describes the relationships between RHAs and health-promoting activity that may help develop or refine RHA and provincial policies. Additionally, the principles associated with a constructivist grounded theory data analysis provide guidelines on how to process the valuable data collected from qualitative key informant interviews. This is particularly useful to this work in which theory building readily accommodates the triangulation of findings and insights gleaned from the RHA primary interviews and documents, the literature and related experiences of the researcher.

In order to unpack the components of the GTM employed in this research, the remainder of the chapter is developed in five sections. First, it is helpful to reflect upon the constructivist nature of the methodology that, like other critical approaches "privileges [the researchers'] own knowledge and understandings with an assumption that these understandings can be a basis for social criticism in themselves" (Spencer et al., 2009, p. 91). Second, attention turns to the selection of two study RHAs located in two different provinces (Ontario and BC) by providing reasons for their inclusion and particular details of their local health systems. This also provides description of the major directional corporate documents (mission and vision statements) of the selected RHAs. Then the chapter shifts to the processes involved in data gathering including the details of key informant interviews. This third section also presents the case that data

saturation was achieved in the interviews. This is a measure of the completeness and quality of the data gathering process. A discussion of the interpretive analysis of the data is presented in the fourth section the chapter. Although this analysis is presented as a discrete and sequential step in the research process, in constructivist GTM, it must be recognized that an iterative process was used where interpretation began with initial data collection. Finally, a fifth section is focused on building theory.

3.2.1 Critical Reflexivity and Personal Influences of the Researcher

As with most qualitative methods, in a constructivist GTM it is important to reflect upon my positionality within the research. There are two main aspects of my recent experience that influence the approach to this research. They are my career as a consultant and manager, especially while working in organizations within the Canadian health system and my experiences with policy development. I discuss these domains incorporating reflections on how these positions and experiences have shaped this project.

I have held several senior management positions that provided first-hand experience with the influential role played by the executive of public sector organizations in interpreting guidelines and legislation that shape corporate culture. Relative to my research, these experiences guided several decisions related to set up and carrying out key informant interviews with leaders in the subject organizations, and also helped greatly in identifying situations of potential conflict or competing interest and allowed for easy interaction with many of the key informants. However, if meaningful difference between my experience and their roles surfaced, I aimed to be mindful and allowed participants to express their particular views without my experience or assumptions knowingly

interfering. This approach is in keeping with interview guidance found in the literature (Brinkmann, 2009).

The second set of experiences relate specifically to my role in policy development within my occupational path. For nine years I served on a municipal council, including three years as a councillor and six years as Reeve. There are many roles that local politicians are expected to fulfill, and developing and legislating policy is perhaps one that requires the most careful consideration. Those holding public office are the only ones who legislate public policy, however, they are only one of the inputs to creating it.

In my experience at local, regional, provincial and national levels, most policy development is focused on a relatively narrow set of concerns, issues or outcomes; yet, the result of the policy usually has broader and farther-reaching implications. This notion of unanticipated policy consequences is also well supported in the literature (Koop, 2012; Pierson, 2000; Merton, 1936). Any policy intervention introduced into complex social systems "cannot anticipate all possible consequences of public policy decisions" (Koop, 2012, p. 517).

In sum, I actively participated in the Ontario and Manitoba health and healthcare landscape for over twenty-five years as a senior manager and as a volunteer on boards of hospitals, public health units, long-term care facilities and a children's mental health organization. I consult with municipal organizations and hospitals in many communities on strategic issues, including the integration of smaller organizations into larger ones as well as program, facility and strategy development. Consultation on policy development, particularly regarding rural health/healthcare and financing, involved interaction with provincial and national bureaucracy and elected leadership. Through these experiences,

I gained an understanding of the workings of provincial and federal health systems, including how and with whom policy evolves within government. Most importantly, however, these experiences have led to a curiosity about the role of regional governance and management in health-promoting activity. These experiences and the knowledge taken from them have contributed to shaping the development of a research methodology.

The remaining sections of this chapter provide details of the use of GTM in this work. To set the stage for what follows however, it is helpful to briefly outline how the remainder of this chapter and the following two have been approached and organized. There are places in this chapter where some details about the empirical work are presented that one could expect to find in the following chapters on research findings. For example, in this chapter discussions about the two cases are fleshed out with details about their corporate documents regarding mission, vision and strategic plan. In another example, when discussing sample size, this chapter also presents details regarding when data saturation was recognized within the interview experience.

More explanatory details are given in this chapter for several reasons. First, the details are important to understand in the context of the methodological choices that were made. It would be unsatisfactory to assert it is important to look at mission, vision and strategic plans in the methods chapter without supporting that decision with providing specifics from those statements and documents. A similar perspective would apply to saturation or on the details of coding.

Second, information around methodological choices presented in this chapter is part of the design. The review of mission, vision and strategic plans was a reinforcing part of

the selection of the two case RHAs. So that information is presented when discussing the selection.

Third, with GTM and its inductive, interpretive analysis of the data, reporting should be structured for clarity and transparency. Because it is difficult to completely separate method from findings in an interpretive and iterative analysis, it could be confusing to present findings as a discrete sequential step.

Finally, the approach used here allows for a focus on the principal findings from the interpretive analysis which are three themes grounded in the data. It is the themes themselves ultimately that comprise the theoretical analysis in this research, not the RHAs, not the RHA documents, not the key informants (Schreiber, 2001). Chapter 4 brings the *Place-making* theme to prominence, putting forth a view that this theme is the dominant concept (i.e., core category within a classical grounded theory analysis) within the relationships under study. Similarly, the two themes of *Creating Space within the Organization* and *Developing Networks: From Maze to Labyrinth* are detailed in Chapter 5.

3.2.2 Case Identification

In this research, the identification of the two cases (one region in British Columbia and one in Ontario) was influenced by the overall research focus on relationships between organizations regarding health-promoting activity. The process involved two steps. The first step was identification of two provincial settings that allowed for meaningful research; and second was the selection of a RHA in each of the provinces.

Two settings were chosen to enrich understanding of relationships between organizations. A decision was taken to investigate RHAs where differences were

expected because of the enabling provincial legislation. Lomas (1996) concludes that the major difference among RHAs was the scope of services devolved or delegated to regions as provided for by enabling provincial legislation. Therefore, to examine relationships with RHAs within any one province would likely produce few if any differences compared with that which could be observed from interviews conducted within RHAs with two different legislative frameworks that determine scope of service.

British Columbia and Ontario were selected because they have legislated different approaches to regionalization, with the former including a significant public health role within the mandate of RHAs. The latter is characterized by RHA structures operating alongside separately governed regional Public Health Units that have the *responsibility* of managing public health programs. Ontario also has a more limited approach to decentralizing regional authority to the Local Health Integration Networks (LHINs), which, along with the continuance of the extant public health authorities, as well as independent primary care providers, local hospital and healthcare service provider boards, combine to, at best, provide a shared approach for health-promoting activities.

There is also a pragmatic aspect to the selection of these two provinces as the researcher is a student in the PhD graduate program in Geography at this University, and his permanent residence is in Ontario. This arrangement afforded easier access to the research communities. Most importantly, however, as illustrated above, the choice of two different provinces allowed for the development of meaningful comparative insights in terms of the research findings.

The case selections from within BC and Ontario were based on a consideration of the demographics, predominant economic activity and settlement characteristics. The

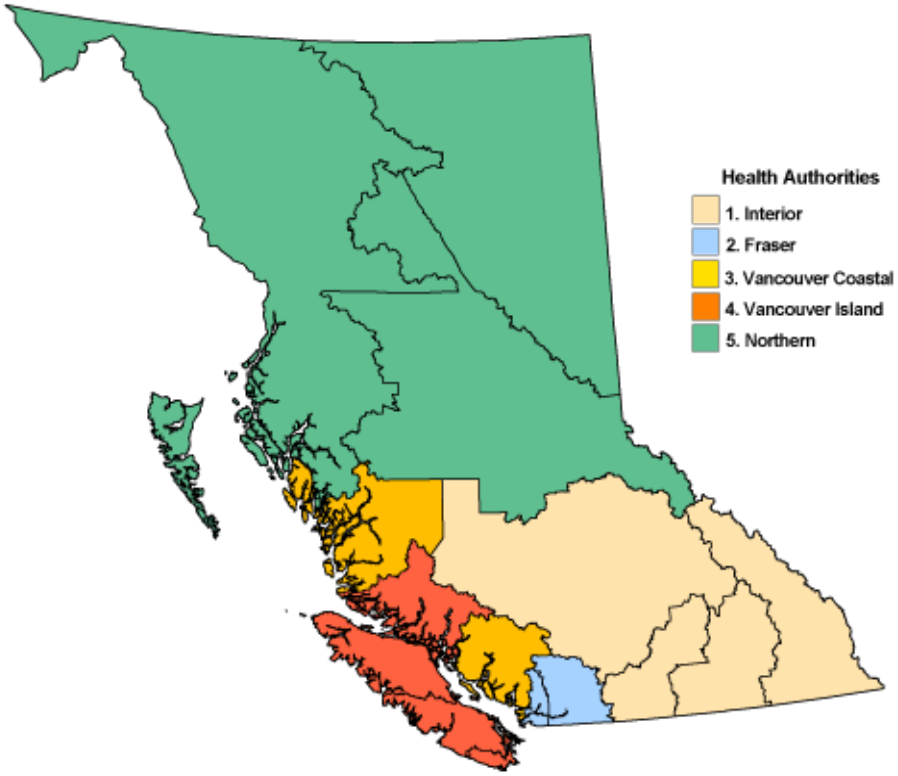
objective was to identify two regional health authorities that present context similar in terms of these broad criteria. By selecting based on their *external* similarities, differences between the provincial arrangements regarding health-promoting activity were emphasized. In BC and Ontario, there are a range of regional health authorities from those serving metropolitan areas to those mostly concerning with rural populations. An analysis identified the Northern Health Authority in British Columbia and Northwest LHIN in Ontario as two RHAs that had many similar geographic and demographic characteristics (Table 3.1).

Table 3.1: Comparison of the Study Area Regional Health Authorities

	Northern Health – BC	**Northwest LHIN Ontario**	**Notes/comments**
Location	Northern part of BC	Northwest Ontario	Northern
Settlement type	Dispersed with some medium sized cities/settlements	Dispersed with some medium sized cities/settlements	Rural
Main city	Prince George size of main city too	Thunder Bay	Also location of RHA administrations
Population 2011	300,000	231,000	
Notable demographics	Aboriginal (18%) 65+ (17%)	Aboriginal (20%) Age 65+ (15%)	Higher than provincial percentages
Mission Statement	Through the efforts of our dedicated staff and physicians, in partnership with communities and organizations, we provide exceptional health services for Northerners.	Develop an innovative, sustainable and efficient health system in service to the health and wellness of the people of the North west LHIN.	
Vision Statement	Northern Health leads the way in promoting health and providing health services for Northern and rural populations.	Healthier people, a strong health system--our future.	
Budget 2013	$750 million	$600 million	In Ontario this includes funding of health service providers
Model/role	Direct care provision	Funding and planning	
Main services provided	Acute care, mental health and addictions, public health, home and community care	Financial, health planning, advocacy, information	
Location	See Map in Figure 3.1	See Maps in Figure 3.2 and 3.3	

Source: Northern Health (2013); NWLHIN (2013)

Figure 3.1 Regional Health Authorities in British Columbia

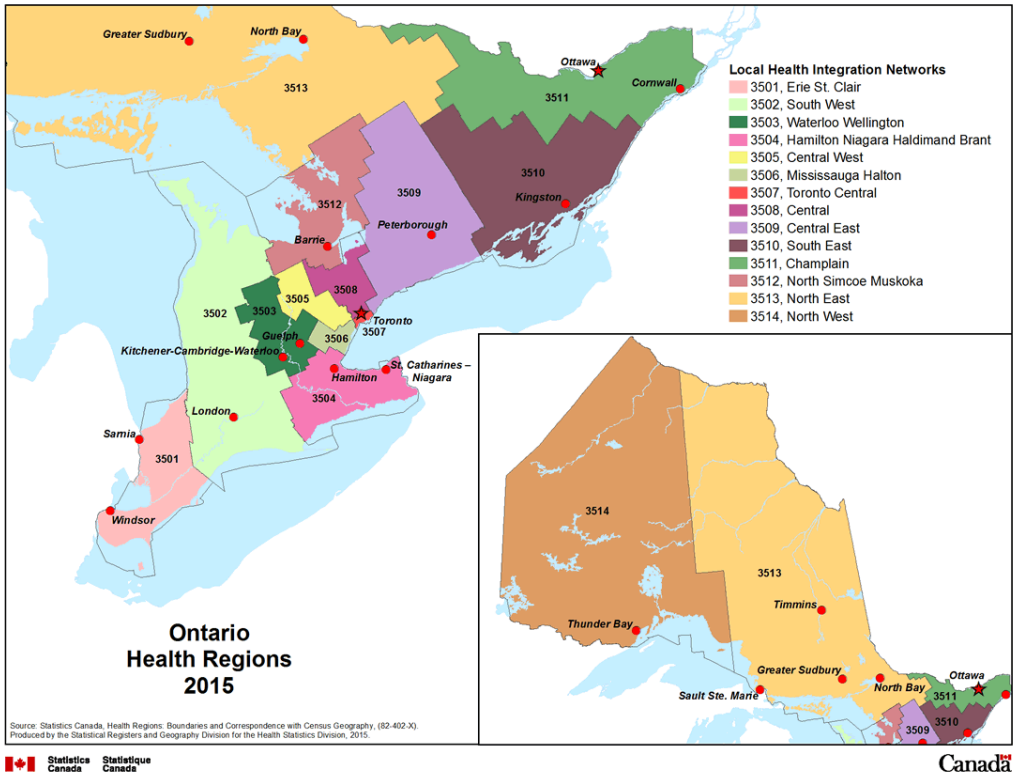


Source: Government of British Columbia, 2015

Figure 3.2 Geographic Map of NWLHIN

Source: Government of Ontario, 2015

Figure 3.3 Ontario Health Regions



Source: Statistics Canada, 2015

3.2.2.1 Northern Health

Regionalization in British Columbia began in early 1993 with the provincial government establishing 20 health boards and 82 health councils. In 1997 this was modified to 11 regional boards, 34 community health units and 7 community health service societies (Benoit et al., 2002). Primarily because of operational duplication, this second schema was substantially altered in 2001 when the RHA network was reduced to five geographic regions, and one province wide RHA responsible for certain services, such as cancer care. In the case of Northern Health (NH), several antecedent organizations were consolidated to form NH and its corporate offices were established in the City of Prince George. This history, in terms of time and transformation, is different than the Ontario experience and may have a bearing on the interpretation of the research results.

NH employs over 7,000 people who provide acute medical care, mental health and addiction services, public health, as well as long-term care and home and community support care. This RHA directly oversees twenty-five hospitals and fourteen long-term care facilities along with many community-based public health units. It serves a population of about 300,000 and had a 2013/14 operating budget of over $725 million (NH, 2014).

The organizational structure within NH responds to both its vast geographic coverage and its broad range of services. Specifically, while the health office is located in Prince George, there are three health service delivery areas, each administratively headed by a Chief Operating Officer.

The Northern Health (2014) website documents its mission as follows: "Through the efforts of our dedicated staff and physicians, in partnership with communities and organizations, we provide exceptional health services for Northerners" (NH, 2014). Its website also outlines that the future vision for the organization includes:

> Northern Health leads the way in promoting and providing health services for Northern and rural populations;
>
> Northern Health is known for our strong primary health care system. People experience seamless and coordinated service. The 'Primary Care Home' is the foundation for multidisciplinary health care and helps people navigate across service.
>
> Northern Health involves people and their families in their own health and health care. Individuals and families feel respected and are treated compassionately.
>
> Northern Health provides high quality health services, using evidence and innovation, to meet the needs of our Northern and rural populations. We are known for the creativity of our staff and physicians and for our innovative use of technology to care for people as close to home as possible.
>
> Northern Health is recognized as an outstanding place to work, learn, and grow. We foster a safe and healthy work environment. Education and development of people in the north, for the north, attracts and retains staff and physicians.
>
> Northern Health works with communities and organizations to support Northern people to live well and prevent injury and illness. The status of Northern people is improving faster than the rest of BC (NH, 2014).

3.2.2.2 Northwest Local Health Integration Network

In Ontario, the modern development of RHAs began in 2006 with the creation of fourteen Local Health Integration Networks (LHINs), with one of them being the Northwest Local Health Integration Network (NWLHIN). LHINs replaced a previous structure of District Health Councils (DHCs) whose role was focused mostly on planning health services governed by volunteer boards. During the transition from DHCs to LHINs the latter first adopted the DHC scope of responsibility generally limited to health

service planning and encouraging cooperation among health service providers, yet with an emphasis on better integration of the health system. Integration was considered an extension of the health system restructuring and consolidation that had occurred through the province in 1996-2000. In 2007, LHINs were provided with health system funding responsibilities wherein they negotiate priorities and allocate operating funding to health service provider organizations (Ontario Ministry of Health, 2007).

The LHINs were superimposed upon the extant health system in Ontario. Thirty-six local public health units, governed by local municipal and provincially appointed representatives, continued to hold accountability for public health. In addition, hundreds of local boards continued to govern hospitals, long-term care and other health service providers throughout the province.

The NWLHIN funds health services providers including hospitals, community care access centres, community support service organizations, long-term care homes, community health centres and community mental health and addiction agencies. The NWLHIN does not directly provide care services. Similar to all LHINs, the NWLHIN employs funding processes to set priorities, draft plans and coordinate health services within its region. In the case of the NWLHIN, it provides these important services for approximately 232,000 people in rural northwestern Ontario from its head corporate offices in Thunder Bay, Ontario. The NWLHIN's processes are conducted with health service providers that maintain their own governance and management structures. In addition, and of special note, there are two public health units that provide service in northwestern Ontario: neither is funded by the LHIN nor does the NWLHIN have any direct governance accountability for public health.

NWLHIN (2014) website reports its mission or purpose statement to be: "Develop an innovative, sustainable and efficient health system in service to the health and wellness of the people of the North West LHIN" (NWLHIN, 2014). Its vision statement reads: "Healthier people, a strong health system: our future" (NWLHIN, 2014).

NWLHIN outlined its four strategic directions in its latest strategic plan 2010-2013 as: "Population Health: improved health outcomes resulting in healthier people; Care Experience: access to healthcare that people need, as close to home as possible; Care Experience: continuous quality improvement; and System Cost: well-managed resources" (NWLHIN, 2014).

The comparability of these two RHAs was reinforced in two separate instances. In personal conversations with Dean Roger Strasser from the Northern Ontario Medical School, he confirmed that his school had undertaken a process in looking for comparable learning environments that led to the same RHAs being identified as being similar in terms of demographics, challenges of great distances and social characteristics (R. Strasser, personal communication, April 2009). Further, in a subsequent interview with a key informant in the Northern Health, it was again mentioned that the comparability between the nature of the two RHA's had led to an educational exchange (BC Participant D, 2011).

The selection of these two specific RHAs minimizes contextual influences in the relationships involving health-promoting activity. Two similar metropolitan RHAs could have been selected to achieve the same objective. So while the RHAs are similar in their rural nature, large aboriginal populations, resource-based employment and other characteristics, this selection of the cases was not focused on how those particular

variables influence the operation of the RHA. The purpose of selecting these particular RHAs was an attempt to have such potentially influential factors offset as much as possible. The meaningful parameter was to have differences in the enabling legislation since it is unlikely that differences surface in a constant environment (Firebaugh, 2008).

As the interviews unfolded however, the rurality of the RHAs appeared from time to time to be a component of the themes and relationships grounded in the data from both RHAs. This led to consideration about how the findings might also reflect or reveal insights about health service delivery in rural and northern areas. As discussed in subsequent chapters on the research findings, this reflection does not undermine the quality of the findings, in fact, arguably it is quite the opposite. Consideration of the importance of the regional (settlement, demographics, etc.) attributes in RHA relationships around health-promoting activity is critical in interrogating further dimensions of RHA policy. Specifically, the question is to what degree can and should provinces reflect influences of location and place when establishing regional structures for and relationships with RHAs. Should RHA legislation and *decision space* be consistent for all regions within a province? This prospect for further research is taken up in subsequent chapters.

3.2.3 Ethics Review and Data Collection

All data collection protocols were approved by the Human Research Ethics Review Board of the University of Victoria, and by the Northern Health (Appendix A). A separate ethics approval process, beyond that of the University of Victoria, was not required by the Northwest LHIN in Ontario.

The two main sources of data for this research are policy and operational documents, such as strategic plans, business plans and annual reports, published by the organizations; and key informant interviews with senior managers.

3.2.3.1 Document Review

Documents provided to the researcher during interview visits plus those available on the website of each of the RHA organizations (NH and NWLHIN) were reviewed on an ongoing basis from 2008/2009 to 2013/14. There were a total of twenty documents of varying length (from a one page report to a 60 page report) and detail. This included principal direction setting documents such as annual reports and strategic plans that articulate mission, vision and the strategic emphasis of the organizations. These documents provide understanding of the direction and priorities that the RHA has set with the scope afforded by the enabling legislation. Other published reports available from each RHAs, such as the reports on certain program initiatives (e.g., NH Road Health; NH Population Health and oil and gas activity and NWLHIN Community Engagement reports), were also reviewed and helped sensitize the interview processes by providing the researcher with insights into the organization prior to visiting the corporate offices. These sources are considered to be grey literature since they are self-published and not peer-reviewed.

A formal technical content analysis was not carried out nor was the document analysis completed separate from the broader interpretive analysis of thematic development that is discussed in section 3.2.4 below. Analysis of the documents was first conducted to set context for the interviews and much of that has been reported with the information on the selection of cases. Also, thematic analysis of the documents

helped crystallize and reinforce themes especially with the important direction setting documents (strategic plans with mission and vision). Initially documents were read, notes were made and common threads identified. Once the themes from interviews were being formed, the document analysis transformed toward thematic confirmation and reinforcement (Prior, 2014). All documents reviewed are cited in the bibliography.

3.2.3.2 Key Informant Interviews

The decision to emphasize key senior management interviews within the RHAs is supported in the literature (Oliver et al., 2013) where it is posited that public health strategy and policy are greatly influenced by managers and leadership in the system. As it turned out, this worked well and interviews were held with RHA senior managers and management staff involved with planning. Strategically, the RHA key informants also acted as an effective portal to other interviews, especially with reference to appropriate provincial contacts in senior positions.

Interviews in both places started as a purposive sample of the senior management team as defined at each respective RHA. In both organizations senior management was defined as the most senior position (CEO) and those reporting directly to the CEO who themselves have managers reporting to them (thus excluding administrative support staff who may report to the CEO). During the interviews the interviewees were asked if there were others with whom it would be valuable to interview. This encouraged a snowball process in which additional individuals both within and outside of the RHAs were interviewed, including senior management in other organizations such as other RHAs or, in the case of Ontario, in Public Health Units. In both BC and Ontario, the referrals led to senior management in the province's Ministry of Health. Interviews with

management of allied agencies (for example, a provincial Cancer Society) were also garnered through a similar reference process. Without exception, all those interviewed appeared comfortable and were knowledgeable discussing RHA responsibilities and health system reforms in general.

There were nineteen key informant interviews ranging in time from one to approximately two hours each. Ten of the interviews were with RHA representatives in British Columbia and nine were with participants in the RHA in Ontario. Ten in-depth interviews were with senior management within the RHAs. Five of the other nine interviews were with the provincial health management team, two were with public health leadership in related organizations (one within another LHIN in Ontario and one in a Public Health Unit) and two were with local allied health agencies (Table 3.2).

Table 3.2: Summary of Key Informant Interviews

Interviews	Northern Health British Columbia	North West LHIN Ontario
RHA Senior Management	7	3
Other RHA	-	1
Public Health	incl. in RHA management	1
Provincial Government – Ministry of Health	2	3
Allied Health	1	1
Total	**10**	**9**

The interviews covered a broad range of experience and expertise as was originally expected from the earliest conceived research plans. What did differ from the earliest plans was the total number of interviews. Once in the field, it was evident that

full representation of the messages from RHA leadership views was possible with fewer interviews than originally thought. The earliest estimates of the number of interviews were not well informed. Schreiber (2001) comments on this very circumstance by noting:

> an exact determination of the size of the population for a study cannot be established *a priori* (Morse, 1991, 2000; Sandelowski, 1995). It is important to remember that the units of analysis are not predetermined and are not known until the data are in hand. The units of theoretical analysis are not the individual participants themselves, but may be incidents, stories, examples and so forth (p. 63).

So the matter of a difference in the initial estimate of the number of interviews and the resultant number was a function of miscalculation of how quickly the findings would reveal the themes produced by the analysis. Charmaz (2006) also comments on the question of sample size minimum:

> Grounded theory logic invokes saturation as the criterion to apply to your categories. As such, some grounded theorists (Glaser, 1992, 1998, 2001; Stern, 2001) argue that you keep sampling until your categories are saturated and that this logic supercedes (sic) sample size – which may be very small (p. 114).

Qualitative interviews should continue until a point of saturation, yet not beyond for both practical and ethical reasons (Charmaz, 2006; Curtis et al., 2000; Francis et al., 2010). While most articles expressly agree with this notion of saturation, there is little in the literature explaining how saturation has been achieved (Francis et al, 2010, p. 1230). Researchers have retrospectively analyzed interview data in search of markers of data saturation. For example, Francis et al (2010) reviewed several studies in detail and suggested an approach where an initial number of interviews (they suggest ten) should be conducted. If saturation is apparent an additional three interviews should follow to confirm saturation. To aid transparency, they further suggest that more detailed

information on data saturation should be included in published work. Guest et al (2006) retrospectively examined qualitative work that involved over sixty interviews. They observed, "…saturation occurred within the first twelve interviews, although basic elements for meta-themes were present as early as six interviews" (p. 59).

These articles are not viewed as being definitive as to the required numbers of interviews and, to be fair, the authors offer sufficient cautions that their work should be viewed as suggestive guidelines especially with samples that are "…relatively heterogeneous, [where] the data quality is poor, [or] the domain of inquiry is diffuse and/or vague" (Guest et al., 2006, p.79). However, the consistent view reflected in these studies is that good quality findings, analysis and rigour emerge from relatively few in-depth and targeted interviews. Further, it is important to regularly assess data saturation within the context of the research and research questions. This means employing a dynamic fieldwork protocol that periodically, and iteratively, assesses saturation.

Such a dynamic and iterative approach was followed in this research. The snowball reference process for additional interviews was curtailed once data saturation was achieved within the various segments. For example, after only two interviews with local allied health agencies, data saturation was reached in regard to the central questions of this research. The saturation assessment was based on the content of those interviews and, importantly, supporting and reinforcing comments from other interviews. Similarly, the themes that emerged around the research questions were sought or confirmed after each interview. When no new themes emerged, the interviews were curtailed with satisfaction that meaningful information had been collected. Further discussion of saturation in this work concludes the next section on analysis.

All interviews were conducted with informed consent, and participants were told that their individual anonymity and confidentiality would be protected.[10] Each interview was audio-recorded and, subsequently, transcribed verbatim by a professional transcriptionist into written format for the sole purpose of analysis by the researcher. In total there were 19 key informant interviews that produced 250 pages of transcription. All materials are kept in a locked file cabinet and in password protected files on computer. All audio recordings and analysis have been kept secure. These records will be destroyed or erased in three years time following the completion of this dissertation.

Eighty percent (15) of the interviews were conducted face to face, while four were conducted by telephone with executive or senior management personnel. These individuals provided in-depth insights of their operations. Each manager had considerable previous experience in comparable health system related positions. There was good reception to participation in the interviews as everyone that was approached readily agreed to an interview. No one declined to be interviewed. All participants expressed interest in the research and offered to be available if any follow-up was required, although there were no follow-up interviews.

Available background literature and corporate documents (mission statements, vision statements, current strategic plans) from both RHAs were reviewed prior to conducting any interviews to provide essential context for the interviews and an appreciation of the general direction and priorities for each RHA. Because of availability and travel schedules, the purposive interviews started with the leadership in the NWLHIN with meetings beginning in Thunder Bay. Then meetings in Prince George

[10] To ensure anonymity, each interviewee was assigned a pseudonym that is used in attribution of the transcript excerpts presented in Chapters 5 and 6 on Findings. Each pseudonym is in the form of (province) Participant (letter). A key informant from Ontario, for example would be Ontario Participant A.

with the leadership of NH followed. Referred interviews had no particular geographic sequencing and occurred face to face in Toronto, Victoria and, in a two instances, on the telephone with individuals in other cities in each province.

Interviews were based upon a semi-structured interview guide (Appendix B). Questions were open-ended and addressed key thematic areas, summarized in Table 3.3 in a form that has been adapted from Shield and Tajilli (2006). The interview guide was based upon academic knowledge and literature, the results of the document review (i.e., grey literature from each of the respective RHA) and from personal occupational experience. With a semi-structured guide, it was possible to adjust in an iterative fashion the emphasis on questioning around certain points as the interviews and concomitant analysis progressed.

Since key informants were drawn from three different types of organizations – RHA, allied and provincial - the actual questions asked were adapted slightly to reflect the different perspectives. For example, the questions around the concept of provincial legislation were modified when talking with provincial health management or those with allied health organizations. Also, it is important to note that interviews conducted later were informed by ideas and comments offered in earlier interviews. This is keeping with the GTM approach of simultaneous data gathering and analysis referenced above (Charmaz, 2006). Nevertheless, the questions remained connected to the central concepts outlined in Table 3.3 and tied to the research questions.

Table 3.3: Conceptual Framework for Development of Interview Guide

Concept	Informed by	Possible questions
Role of Management The role of senior management in setting priorities and fostering relationships with other organizations Role of strategic planning Developing networks	Personal experience and organizational annual reports Academic literature.	Please tell me about your career to this point? Can you talk about your experience with RHA implementation? What is your understanding of regionalization? And your role in regionalization?
Provincial Legislation The influence of legislation and contracts in establishing or limiting an organization's *decision spaces* or role around placing priority on health-promoting activity Relationships with provincial departments of health/public health	Respective provincial legislation Academic literature	Do you feel the RHA structure helps or hinders development and implementation of your health-promoting agenda and if so, how? How do you work with other organizations to promote healthy populations?
Community Interaction Vulnerable Populations or Populations Served. Consider how a focus on marginal populations can be an acid test of the nature or strength of an organization's focus on population health.	Personal experience, RHA grey literature Academic literature	What is your relationship with local communities? Local government? How do you address the needs of vulnerable populations? (Who are vulnerable populations in your RHA?) How much flexibility do you have to focus on the health needs of specific populations?

Key informants were provided an information letter describing the study and each signed a form or provided verbal consent securing their interest in participating in this study. At the outset of each interview, the researcher took the time to establish rapport with interviewees, setting a tone that was casual and conversational and non-threatening. This too is in keeping with interview processes inherent to successful GTM (Bryant, 2014).

With a semi-structured format, it was possible to allow participants to pursue a tangent that was often meaningful and added quality to the data that were gathered and interpreted. To assist with validating the findings, a form of real time member-checking was employed whereby the researcher confirmed comments provided by the interviewees by phrasing a synopsis of what the researcher was hearing at various stages throughout the interviews. Generally member-checking "…refers to taking ideas back to research participants for their confirmation" (Charmaz, 2006, p. 111). In this study, the interviewees were asked whether the synopsis was accurate at the time of interviewing. This process engaged the interviewees not only in providing information, but also in ensuring the researcher accurately understood the information they were providing.

Interviews were conducted until it was apparent that no additional insights were being offered around the core research questions. This is in keeping with the GTM literature that suggests that interviews normally continue until a point of data saturation when "…no new themes, findings, concepts, or problems are evident in the data" (Francis et al., 2010, p. 1230).

3.2.4 Interpretive Analysis

As data were gathered from the documents and the interviews, themes or patterns grounded in the data were revealed and confirmed and established through further interviewing and analysis. This process allowed for an in-depth representation of the cases (Bryant, 2014; Charmaz, 2006; Creswell, 2007; Luker, 2008;). Although interpretive analysis is expressed as a discrete step here, it is acknowledged that during the GTM qualitative data collection process there was ongoing interactive analysis occurring.

Miles and Huberman (1994) reference work by Carney (1990) that refers to three levels of analysis leading from data formation to synthesis into an explanatory framework: summarizing and packaging the data; repackaging and aggregating the data (theme development); and developing and testing themes to complete understanding (up to saturation).

Although Carney's model represents a structural and sequential process, entitled, the '*Ladder of analytical abstraction*,' that does not adequately reflect the iterative process that was employed here, it does provide a valuable characterization of the transformation from data, into coded data, into theme formation and deeper understanding. In this way, Carney outlines elements of data analysis and provides context for ensuing interpretation and theory building.

Analyses began with a careful review of the interviews. Audio files were confidentially transmitted via *Dropbox*, to the transcriptionist. Upon return, each transcript was reviewed for accuracy by the researcher. During this reading, rough margin notes were made that helped contextualize any non-verbal communication, such as added emphases, that were evident on the audio files, but not in the transcripts.

A second component of the early analysis involved creating initial codes that were expressed in terms of actions or processes as expressed by the key informants. In this research, coding was done by segments of data as opposed to line by line. The initial codes used to analyse the interview data are listed in Table 3.4. Glaser (1978) asserts that coding with gerunds helps "detect processes and [helps the researcher] stick to the data". Charmaz (2006) notes that coding in GTM consists of at least two main phases: "1) an initial phase involving naming each word, line or segment of data followed by 2) a

focused selective phase that uses the most significant or frequent initial codes to sort, synthesize, integrate and organize large amounts of data" (p. 46). Table 3.4 also summarizes selective coding and illustrates how the selective codes nest with the major messages (themes). Moving from initial coding to selective coding involves analyzing similarities and common patterns in both the literal messages contained in the transcripts (open coding) and also being attentive to latent ideas and concepts that present between the lines or across several interviews (axial coding) (Bryant, 2014; Charmaz, 2006; Glaser, 1978).

A quick summary of the ideas (or sub-themes as it turned out) was done for each transcript as it was received, which allowed for two concomitant analytical steps. First, there was a continual analysis of saturation. Closely related, yet separate, was an analysis of common or broad themes that surfaced in each interview and across interviews. The interpretation of interviews and identification of themes are usually discrete activities as envisaged by Carney (1990), but in a GTM approach they are processes that evolve together from the initial interview (Charmaz, 2006; Luker, 2008)

Table 3.4. Summary of Coding Structure: Showing Initial Codes, Selective Codes and Themes

List of initial codes	Selective Codes	Theme
Coordinating health providers	Community	Place
Exploring integration opportunity	Healthcare	Network
Leading (innovation and change)	Partnership	Network
Setting direction	Leadership	Place
Localizing programs	Community	Place
Processing reports	Administration	Org. space
Identifying health needs	Planning	Place
Justifying expenditures	Administration	Org. space
Not strategizing/reacting to situations	Administration (central)	Org. space
Partnering	Partnership	Network
Convincing	Partnership	Network
Focusing on healthcare	Healthcare	Place
Resisting by communities	Community	Place
Community Consulting/engaging	Community	Place
Limiting authority	Administration	Org. space
Planning programs	Planning	Place
Advocating	Leadership	Place
Defending role	Partnership	Org. space
Governing or administering	Administration	Org. space
Influencing HPA	Leadership	Place
Integrating	Leadership	Place
Strategizing	Leadership	Place
Empowering	Leadership	Place/Org.
Aligning	Leadership	Place/Org.
Assuming leadership	Leadership	Place/Org.
Setting example	Leadership	Org. space
Responding to community voice	Community	Place
Reorienting views of system	Community	Place
Balancing investment	Resources	Org. space
Building and transforming support	Community	Place
Progressing health prom. focus	Change	Place
Supporting staff	Resources	Org. space

Legend:

Place = Theme 1: Place-making – the organization's efforts to permit and encourage those served to view the RHA with special meaning to their sense of place and well being.

Org. space = Theme 2: Creating Space in the Organization – the willingness of a RHA to support and invest in population health and health-promoting activity regardless of limitations that may exist on a strictly prescribed scope of service.

Network = Theme 3: Developing Networks: from Maze to Labyrinth – the ability to establish networks and relationships that allow assured, lower stress, access to all levels of prevention, diagnosis, and care to all populations served.

The analysis of the data and development of codes and then themes was supplemented by a deconstructive stance that included examining dichotomies, understanding what has not been said, focusing on contradictions, exceptions and metaphors (Creswell, 1997, p.153). Carney's conceptual framework again guided this process of identifying and organizing the relationships between health authority development and health-promoting activity.

Charmaz (2006) and Bryant (2014) stress that open coding in constructivist GTM should be approached with an open mind receptive to ideas and views grounded in the data. In advocating this view they also cite Dey (1999) who has stated that 'There is a difference between an open mind and an empty head' (Charmaz, 2006, p. 48). While initial coding is open, the determination of selective coding and the subsequent grouping into themes involved incrementally increasing input and interpretation from the researcher.

The final outcome of the interpretive analysis was the identification of three principal themes that, in turn, formed the foundation for addressing the research questions, and for building a theory of therapeutic regions. Critical comparative analysis of the similarities and differences across the two regional health authorities both shaped and reinforced the identification of the main themes.

Table 3.5 shows how the chronology of the interviews influenced the development of the themes. Two observations should be clarified from this overview. First, the interviews with senior management conducted early in the research revealed the initial conception of the themes, yet the number of interviews required for ideas and concepts to

be forged into identifiable themes varied. For example, the earliest interviews provided insights into the first theme (that theme is *place-making* as is detailed in the discussion of the research findings); however, it was the accumulation of data from several interviews that sparked the conceptualization of *place-making* as a theoretical insight. Second, reinforcement and strengthening of the themes emerged as the interviews continued. And, as is evident in Table 3.5, the pace of reinforcement varied by theme.

Table 3.5 also serves as a bridge in this chapter between data gathering and analysis, which is the next part of the GTM process. The information in Table 3.5 was compiled based on notes and earlier versions and was only considered final once all interviews were completed and the themes developed. It offers a representation of the iterative process experienced over the interview period. And, while the precision of the assessments in Table 3.5 as to whether a particular interview was part of the genesis of a theme or of its development or subsequent confirmation can be debated, the overriding message is that the interviews continued until no new themes emerged.

Table 3.5: Graphic Representation of Process of Achieving Data Saturation

Themes[11]																				
	KI >	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1 Place		G	G	G	G	G	G	G	G	G	D	D	D	D	D	D	**S**	C	C	C
2 Space		G	G	G	G	G	D	D	D	**S**	C	C	C	C	C	C	C	C	C	C
3 Network		G	G	G	G	G	G	G	G	G	G	D	D	D	D	D	**S**	C	C	C

Legend:

KI: Key informant interviews, listed chronologically
G: Theme genesis
D: Theme development
C: Theme confirmation and refinement
S: Saturation

3.2.5 Theory Building Process

This component of the methodology synthesizes the themes and propositions to help construct a new explanatory framework for understanding the relationships under study (Carney, 1990). A theory of therapeutic regions is built upon these new understandings of the relationship between RHAs and health-promoting activity that are grounded in the data of this research. This theory applies to the current concept of therapeutic landscapes, offers a heuristic of RHA development in implementing health-promoting policy and provides insights into provincial policies for regional health

[11] The themes are explained in full detail in subsequent chapters.

authorities in the realm of health promotion. Additionally, it aims to spur new ideas and open doors for subsequent research.

3.2.6 Presentation of the Findings by Theme

How the findings are presented is an organizational decision. GTM involves iterative analysis and offers several ways that the findings can be presented. Arguably, for this study involving two RHAs, two sources of data (interviews and corporate documents) and three themes, the findings could be presented in many different ways. Reporting the findings by theme was chosen for this work. Prior to reaching this decision, two steps were taken. First, rough draft outlines were developed to indicate which approach would allow for easy and effective readability. Writing from the themes was perceived to allow for a clearer representation of the results of the interpretive analysis.

Second, literature about how best to present thematic, grounded theory results was consulted. Gilgun (2014) addresses the challenge of balanced analysis and writing in a constructivist paradigm. She suggests that priority is given to the "voices of research participants…[and] voices and analyses of researchers do not dominate except in some articles whose purpose is theory development or the presentation of theory. Researcher analyses often are important, especially in putting forth social action recommendations that stem from the experiences of informants" (p. 659). Gilgun (2014) goes on to suggest there is flexibility in how findings are reported as long as the reporting "make[s] sense and is consistent with the purpose of the research" (p.664).

Charmaz (2006) offers additional support for an approach that allows the analysis to play a formative role in the format of writing reports of constructivist GTM:

> The emergent character of grounded theory writing may conflict with class report or dissertation requirements. Residuals of positivist dominance cast shadows over how we frame our research reports – sometimes long shadows.
>
> Required formats often presuppose a traditional logico-deductive organization. Thus, we need to rethink the format and adapt it to our needs and goals rather than pour our work into standard categories. Rethink and adapt a prescribed format in ways that work for your ideas rather than compromise your analysis. (p. 154)

Within a constructivist approach, empirical data are interpreted by the positionality of the researcher informed by prior personal experience as well as perspectives drawn from relevant literature. Inherent to this approach is the challenge of ensuring fair balance among the interpretive lens so as to allow each to bring light to the analysis. This approach reflects the inductive reasoning process that is based on the evidence and built knowledge that moves from the particular facts grounded in the data to the general proposition represented by themes (Saldana, 2009). Finally, in this dissertation, the organization of the writing by theme is intended to bring clarity to the theory development, which is a primary goal of this research.

3.3 Strengths and Challenges of the Research Design, Methodology and Execution

The research design and methodology employed here presents both opportunities and challenges. Ultimately, the focus on RHA senior executives allows for access to key decision-makers who have advanced experience with policy both within the RHA and, through referral, in the provincial government. Additionally, the semi-structured questioning format with opened ended questions consistent with the GTM approach permits participants to have more control in their responses that offers them valuable reflection time and informed speculation. It also facilitates the researcher being able to reflect upon the responses and to consider how to further advance the discussion.

There are also several challenges that influence the contributions of this research. At a macro scale, there is the challenge presented by the dynamism of regionalization in Canada. Many of the current regionalization initiatives began in the late 1990's and provinces proceeded at varying rates to implement and modify their schema for the following 20 years. There have been periods when there have been major modifications to various regionalization schemes as outlined in Section 2.1.2 and Table 2.1. Most recently, in the last 10 years, there has been little change. To some extent this type of periodic dynamism is commonplace in health and healthcare systems involved with many actors and influences. While these dynamics may not alter the utility of the findings generated by this research design, since all regions forge relationships with health-promoting activities, the consideration of the findings and any subsequent take-up must focus on the nature of the relationships. The evolution inherent in regional structures further underscores the inappropriateness of generalizing across all RHAs.

A subset of the aspect of the temporal dynamics is the relative positioning of the two case RHAs. Northern Health has been around for about 15 years in its current form and has had a more or less consistent mandate throughout that time period. NWLHIN has been around for about 10 years and has had a mandate that has shifted, and is poised to shift again. It took Northern Health two strategic planning cycles (about 10 years) to fully embrace health-promoting activity in its strategic plan. These differences do not confound the findings and actually likely accentuate the differences between the two. Also, given current approaches to regionalization, it is unlikely that the two will ever approach public health mandates in a similar fashion. In spite of that however, it is

important to be sensitive to the relative maturation of the RHAs in this initial investigation of the relationships under study.

At the level of the individual interview, it seemed evident that some senior managers may have never previously thought of the relationship or influence between RHAs and health-promoting activity. In the case of the allied health organizations, this potential concern was ostensibly realized as it quickly became apparent that those organizations had little programmatic interaction with RHAs because of fundamentally divergent mandates. This is discussed further in the reporting of the research findings.

The very choice of GTM offers both strengths and challenges in this research. With an objective to understand the relationships between regionalization and health-promoting activity, GTM offers a method that is not constrained by initial hypotheses and pre-determined outcomes. However, there is a need to test the themes that have emerged from the two jurisdictions under study. The GTM approach of research-theory-hypothesis can often reveal new theory for consideration but it also brings a certain open-ended nature that points to further research to test and refine theory.

Chapter 4: Research Findings - Theme 1: Place-making

This research is centrally concerned with regional health authorities (RHAs) as health-promoting administrative bodies. To develop an understanding of how regions appear in this manner, this and the following chapter report on the research findings based upon the interpretation of the data grounded in RHA corporate documents, and in the key informant interviews with the leadership in RHAs and other associated organizations.

The interpretive analysis of these findings revealed three themes. The primary goal of this chapter is to develop the theme of *place-making*, and illustrate how this theme is grounded in the interview and document analysis data. In doing so, the chapter illustrates relationships to *place-making* between RHAs, the communities and populations served. The next chapter reveals two additional themes that are considered supportive or subordinate themes to place-making. Those themes are related to whether and how a RHA both *creates health-promoting space within its organization* and works to *develop networks.*

The overarching story that emerges from these data is situated in the metaphor already discussed and attributed to Sternberg (2009) in which the health system is viewed as being more like a maze than a labyrinth. This metaphor is used specifically in the characterization of the third theme of *developing networks*, yet it is also useful to characterize the relationships between RHAs and health-promoting activity. From the findings that are reported below, it is evident that the health authorities in Ontario and British Columbia have a different, unique story to impart when it comes to their

relationships with health-promoting activity. On the one hand, in BC the RHA developed its legislated scope and does more to encourage and advance the level and access to health-promoting activity (toward a labyrinth), while in Ontario the RHA is constrained (in a maze) even though its guiding corporate statements point to a future vision aimed at improving population health.

The evolution of the place-making theme started from understanding the concept of RHAs' relationships with communities. However, the contrast between the two case RHAs in terms of the degree and role of community interaction indicated that the community relationships exist on different levels. The interpretive analysis continued and involved simultaneous and repetitive actions that led to the consideration of place-making as a core concept. Those actions included re-reading of interview transcripts, reflecting on the coding of the interviews, parsing the language in the corporate documents, and further reading of literature on ideas of place.

In order to better understand the theme of place-making, this chapter first briefly reviews concepts of *place* and how they relate to the context of this dissertation. The chapter then explicates the relationships of place-making from both a conceptual and operational perspective. The operational perspective is offered in the form of an analytical framework of *relational place-making* posited by Pierce et al. (2010). That framework guides the presentation of the findings that reveal the place-making theme.

4.1 Place

Casey (1997) notes that modern thinking about *place* is not a quest for "anything like a definitive, much less an eidetic, search for the formal structure of place. Instead, current research tries to find place *at work*, part of something ongoing and dynamic, an

ingredient *in something else*" (p. 286). Casey continues by suggesting that the *something else* could involve a range of academic and intellectual investigation including, as examples: history, the natural world, the political realm, gender relations and sexual difference, and architecture. Casey specifically includes "… in geographic experience and reality (authors such as: Foucault, Tuan, Soja, Relph, Entrekin), in sociology of the *polis* and the city (Benjamin, Arendt, Walter) …" (p286).

Relph (1976) conceives of place as experientially based, denoting relationships with space along "a continuum that has direct experience at one extreme and abstract thought at the other …" (p. 9). In Relph's (1976) conceptualization, an individual's identification of, and with place, can be described by three components including: the physical setting, a place's activities and the meaning created through experiences in a particular place (p. 45).

Agnew (2005) offers that insights result from analyzing the dyad of *place and space* and in doing so he dismisses the *either/or* propositions of space and place that have characterized most geographic and social thought. He proposes there are three aspects to geographic place, namely location, locale and sense of place. He cites that various approaches have surfaced to pull the meanings together that offer insight into the relationship between place and place-making. Two approaches in particular allow deeper understanding of the relationships evident in the data from this research.

The first approach provides a focus that "lies in relating location and locale to a sense of place through the experiences of human beings as agents" (p. 89). Agnew's expansion of this humanist or human agency-based view is that place is experienced as "changing constellations of human commitments, capacities and strategies" (p. 90). This

type of action involving human commitment and capacity can be closely and practically associated with actions taken to promote an individual's or a population's health as reviewed earlier. For example, Nutbeam and Wise (2009) note that successful public health interventions are usually accompanied by high levels of [local] community involvement and support.

The second perspective outlined by Agnew (2005) builds upon the viewpoints brought forth by Doreen Massey (1994; 1999) where she characterizes the differences or similarities among the three concepts of place outlined by Agnew (2005) but with place, defined by social relations. Massey (1994) asserts that the experience of place varies by the "articulated moments in networks of social relations and understandings, but where a large proportion of those relations, experiences and understandings, are constructed on a far larger scale than we happen to define for that moment as the place itself, whether that be a street, or a region or even a continent" (p. 154).

Massey's views evoke the agency of the region. Casey (1997) avers this potential positioning of regions as place with the view that "[a] region is, as it were, midway between a purely relational and an absolutist conception of space and is their common ground, their go-between (p. 189). He notes that it is possible to discern the influence of a region "at a far larger scale than the place itself" (p. 189). Ultimately, Casey sees the region as being able to shape a sense of place (p. 190).

4.2 Place-making

Based on the preceding views, the concept of place is relational. It is socially constructed, dynamic and as Casey (1997) states "at work in something else." (p. 286). Place-making, then, can be seen as a process by which people iteratively create and re-

create the geographies in which they live and experience based on the concept that all places are relational and socially formed and changing (Pierce et al., 2011). Place-making involves spatial and social relationships that evolve and are recreated based on experiences (Massey, 2005). Place-making is as much about understanding the iterative forms of social and spatial interaction as it is about a focus on boundaries or territory (Harvey, 2005).

Pierce et al. (2011) explicate the concept of *relational place-making* and offer an analytical framework for empirical investigations. The four steps of the framework include: identifying a conflict or relational context for examination of place-making; identifying place-frames that shape the perspectives of place within the conflict/context that was identified in the preceding step; identifying the key actors and institutions involved in establishing the place-frames; and finally, "unpack[ing] and interrogat[ing] the place bundles" informing the actors' positions (p. 61).

It is helpful to have additional clarity around the terms used in the steps outlined in the framework by Pierce et al. (2011). The first step suggests that with place being relational, it is important to begin either with a particular conflict or points of agreement, based on social interaction, as opposed to a predetermined concept. The authors suggest that a focus on conflicts or agreements accentuates the perceptions and relations that define place.

The second component of the framework by Pierce et al. (2011) identifies the context or conflict over what is referred to as *place-frames* a term used to capture the result of the process by which people understand place and "especially communicated through social negotiations, including conflict and difference" (p. 60). In British

Columbia and Ontario the legislation suggests that the RHAs are framed by the Provinces as places of *administrative implementation* while the RHAs tend to frame their place as *advocates for individual and community well-being*. It is possible there can be several different views of a region as place.

Their third step involves understanding the actors and institutions involved in developing the place-frames. Piece et al. (2011) differentiate between "those who successfully *produce and reproduce* specific place-frames and those whose positionality gives them particular power to *choose or blend* the frames on offer" (p. 61). Based on Massey's perspective of "places as bundles of space-time trajectories," Pierce et al (2011) suggest that by unfolding the place bundles it is possible to better understand the position of the actors and their sense of place (p. 59). Developing an understanding of positions of the actors and institutions involved is the fourth step of their approach.

It is not the purpose of this work to test or affirm these concepts of relational place-making, rather the approach is presented as an aid to sensitize the presentation of the findings. It is the purpose of this work, however, to draw insights from the data that help with understanding the relationships under study. The approach taken by Pierce et al. (2011) notes that a relational place-making approach "should focus analytical attention on the place/bundles drawn on by actors in the place-framing process in order to identify points of contention or commonality …" (p. 60). This suggests that the door to understanding relational place-making is opened by the actors who construct the place-frames. In this thesis the actors are the key informants who open the door with their comments and with the documents that they have crafted.

Excerpts from the key informant interviews offer insights into the nature of the place-frames and relationships between the province and RHAs, particularly around emphasizing health-promoting activity. In both British Columbia and Ontario, these relationships are dynamic and continue to evolve. This is a result of the evolution of the regional schemes as well as a function of the delegated authority provided to the RHAs by the respective enabling provincial legislation.

To understand the place-making theme revealed in this investigation, highlights and excerpts from the British Columbia and Ontario interviews are presented with a focus on distinguishing the similarities and differences between the two RHAs. A closing section then ties the findings back to the guidance provided by the model of relational place-making offered by Pierce et al (2011).

4.3 Discussion of Place-making in the Study RHAs

4.3.1 Northern Health

In the case of Northern Health (NH), the framework from Pierce et al. (2011) helps develop the concept of place in relation to the region itself and its individual communities. With the initial implementation of regionalization, NH experienced conflict over its own identity both within the broader context of the province, and with its relationships to its local constituent communities. This matter of regional identity is evident in statements regarding the two-stage implementation of regionalization that occurred here and that was detailed earlier in section 2.2:

> *Northern Health was sixteen organizations before we became [the current] Northern Health. [In] the previous round of regionalization, we had regional health boards wherever we had a regional hospital and everywhere there were community hospitals they had what were called, 'community health councils' and then representatives from them sat on a 'community health services society' that ran the community programs. So, it was a very convoluted governance structure*

> *and they really struggled to move anything forward for the North.* (BC participant H)

> *There was some effort from all the CEOs from all those 16 organizations to come together in this council of CEOs to try to influence the provincial picture. When Northern Health was formed, the north became one of six [regions] and we came to the table with the same level of influence as any other organization. The board chair has the same level [of influence] as any other board chair, which was not the case when we had these many small hospitals. The large regions ruled. For the North, regionalization has been a really good thing. It has enabled us to shift the power base a bit in the province in terms of health care. We probably think there should be more done.* (BC participant H)

In BC, regionalization provided clarity around regional governance yet drew attention to the local concerns. The establishment of fewer, and larger, regions consolidated authority and yet resulted in dynamic and yet unsettled relationships with local communities.

> *One of the concerns locally about regionalization was because in the past each small community had their own voice and looked after their own affairs. The concern they had about regionalization is that a lot of the services would be withdrawn and obviously the argument of volume is important if you want quality. So there was a big concern that less and less* [sic] *services would be available in the smaller communities, which means that they would lose professionals - they would lose manpower. The communities [would] literally get smaller. This is a continual concern.* (BC participant D)

Participant D highlights a loss of place literally at the community level even though the creation of the current NH put more authority in the hands of the governance structure of the north. This decentralization paradox is evident when the central authority, or in this case the Province, decentralizes power to regional authorities which brings with it the centralization of authority from the local to the regional scale. In terms of the place-making conceptual framework advanced by Pierce et al. (2011), this relational conflict encourages the actors in communities and regions to *place-frame* and "shape perspectives on that conflict" (p. 61). Pierce et al. (2011) argue that this 'framing'

is a contestation of the place-frames between the needs of the local community and the mandate of the regional authority. In the context of health-promoting activities, this situation can be characterized as a contest between the individual public health needs of any one community within the larger region, and the population health needs of the overall region. The following excerpts serve to emphasize these points about local planning and growing community connections:

> *Local government is probably more important to the health of 90% of the people than any other level of government. So there is a lot to be said for it. I think one of the negative effects of regionalization that I did notice when we first reorganized here is that loss of connection between Public Health and local governments.*
>
> *Yes, but you know what I want to say is that it is coming back. We [the region] are getting back into a relationship with communities through a process called Healthy Communities and Healthy Built Environments and things like that.* (BC Participant P)

These challenges arise beyond a program level (e.g., Healthy Communities and Healthy Built Environments) and manifest in the dual often conflicting mandates for community volunteers and health professionals. For example, volunteers, especially board members, share an affinity for representing and advocating for their local home community while at the same time addressing the obligations of serving the best interests of the entire region. This situation was articulated in several of the senior manager interviews and is typified by the following:

> *One thought occurs to me that [this 2002 reorganized] broader region allows you to continue to establish principles and strive to fulfill them. In an individual community, you will continue to be pulled back, I think to some extent, by the general generic majority interest.*
>
> *If you're in a community, that's going to be a bit of a challenge because what if your board members are comprised of business people in your community and you're talking about putting in a homeless shelter downtown or whatever. Good*

> *luck with the discussion. Whereas, a region can engage in that discussion and keep it at a what-is-the-greater-good level. A [region] board member does have the opportunity to say "I'm wearing my board hat today for this discussion as opposed to my business hat". I think that is a big plus because at the individual community level you will always have those kinds of direct interests.* (BC participant G)

Understanding that the conflict over place-framing occurs at both the program and individual levels, and as noted above brings attention to the role of the actors in place-making. These are multi-layered because of the numerous roles fulfilled by most actors, such as a locally elected community representative that is appointed to the RHA board. The above example is representative of the way that those involved with regional health systems with local delivery expectations often need to frame place from the perspectives of both the local community and the region. Instead of the competing place-frames at an organizational scale of analysis (region in conflict with community and vice versa), the health system tends to promote multiple scales of place-framing among the actors. So, framing the region as a place with accountability for the health of all 'northerners', for example, supports place-making in individual communities. An example of these relationships is revealed in the following two excerpts from the interviews:

> *I think absolutely that there was a sense that what you're going to do is suck all the resources [into] Prince George. You're not going to listen to us at all, we'll have no say but I think the first thing [regional management] did, and it has continued, was bend over backwards to keep that community focus so each community or cluster of communities has a health service administrator (HSA). For the most part those services are devolved to the community. So that HSA isn't just a figurehead talking regional rhetoric.*
> (BC participant G)

> *We have 7000 employees in Northern Health … and a budget of almost $700 million. That's significant even though we are the smallest [region] in the Province, it's not a small organization. We are the biggest employer in Northern BC. It's a big organization and it has all the bureaucratic problems that go along*

> *with that. On the plus side, it has enabled us to set up infrastructure, for example, in medicine – setting up the whole infrastructure around medical staff. That was very flawed up until we became Northern Health. We were able to take [actions] that develop departments, develop medical staff, infrastructure, have a functioning Northern Health medical advisory committee and establish rules. We have a much healthier relationship with the medical staff as a result of that. That's one example.* (BC participant H)

Several of the management interviews suggest that over time community engagement and strong two-way communications and interaction within NH have fostered place-framing and have mitigated any perceptions of an imbalance of power between the region and the local community:

> *We have a pretty extensive community engagement process. The board has a consultation process that they do every second year. They've done five of them and they are broad based population health kinds of topics that they choose.*
>
> *They are board mandated. The report goes back to the board. Many of the board members will attend the community meetings if they come from where they are held.*
>
> *This is a Northern Health initiative. It is mandated by our board to do this. I don't know if the other [regional] boards do something similar or not. We did one on "Let's talk about health" the first one which was a population health kind of discussion. …. Then we did one on "Let's talk about mental health and addictions" that was a burning issue that was coming from many of our communities. Mental health and addictions are big right now across our region. Then we did one on "Let's talk about cancer care" and that came because we were working on our cancer strategy making a case for a cancer centre in the north. Then we did one on "Let's talk about primary care" and then we are doing one on "Let's talk about men's health".* (BC participant H)

This community engagement focuses on regional population health concerns that resonate locally for each community and that facilitate individual and community advocates to talk about health concerns that are particular to them. The region frames its regional 'space' issues in the context of the local place. This brings further conflict within role definition of those in health leadership positions:

> *One thing we are very clear about is that we are an entity of the will of government. We're not actually accountable to the community. We have to make that really clear because there is an expectation from some of the communities that we are to do what they want us to do. What this board has said is, "understand that but also understand that we believe we are here to serve the community and we also are close to our communities and we want to engage with the communities."* (BC Participant H)

While this indicates that the region is not *accountable* to the local community, an overriding message that this participant communicates is that in spite of the limited legislated reality of the decentralization arrangement in BC, the NH *believes* that the region is to *serve, be close to, and engage* with communities. Participant H stresses that they believe it is up to them to actualize their mandate based upon serving community needs. For example, the board directed community engagement suggest Lomas' concept of 'scope' or Daniels' concept of 'decision space' outline an accountability framework, but not an immutable prescription for how they will interact with communities.

Northern Health faces the geographic challenge of a large area and low population density (as does NWLHIN). It also exercises operational flexibility to respond to the needs those challenges present. For example, with senior management distributed across health service delivery areas and the ability to bring professionals together at the local level, NH emphasizes the local community over the regional entity although legislated accountability suggests otherwise. The fact that Participant H perceives that regional board members have the liberty in their decision-making to differentiate between local interests and regional priorities also indicates that there is a balance between the region and the local scale.

The story of place-making is also evident in the NH mission statement, vision statement and strategic plan, referred to as principal corporate documents. The mission

statement and vision statement of NH (presented earlier in Chapter 3) reveal an organization that is empowered to provide health-promoting services, not just healthcare, and that sees a future that emphasizes health promotion and health services for the benefit of northern people. By including health promotion as a priority in its vision statement, NH is acknowledging that excelling in its provision of health services requires up-stream health-promoting activity. In doing so, NH views healthcare and health promotion as connected and not isolated activities. This mission statement says that advancement of both healthcare and health promotion policy objectives are required to yield improvements in northerners' health status.

NH corporate statements are also noteworthy for their identification and focus on the particular health needs of its population. There is no specific mention of provincial priorities or provincial organizations in the provision of care. Rather its focus is on NH being *of the north* and *for northerners*. Its slogan for NH, *The Northern way of caring*, also emphasizes its focus on responding to the health needs of the north. This slogan connotes the north as a special and meaningful place. The capitalization of *Northern* identifies the communities served by NH within a broader area identifiable by this proper-name place. Further, by stating that their mission of caring, is modified to meet the special needs of the north invites a more open relationship exhibiting heightened sensitivity between NH and its communities and population. In other words, Northern Health encourages the local population to see NH as being *of* the north, not as a regional administration imposed upon the local citizens.

In order to fulfill its purpose and move the organization toward its vision, the prevailing strategic plan for NH includes four strategic directions: "Integrated Accessible

Health Services; A Focus on Our People [staff]; A Population Health Approach; and High Quality Services" (NH, 2014).

The inclusion of population health being one of the four strategic directions of NH is significant. First, it is important to understand the use of the term *population health* and how it relates to health-promoting activity within the context of the NH case. Population health in NH refers to a perspective that looks to improve the health of a population using a complete range of health promotion, prevention, diagnostic, treatment and follow-up therapies and services (McKee et al., 2009; Young, 2004). Adoption of the term *population health* within an organization signifies a systematic approach and programs aimed at improving health status for a group or population along with the programs for individuals who require healthcare. With this understanding, several important observations about NH and population health can be made.

First, it is unusual to see population health raised to the importance of being one of the key strategic drivers for a regional health authority whose budget and activity is overwhelmingly focused on the provision of healthcare, regardless of the provincial enabling legislation. The prominence of population health as a key strategy was explored during the key informant interviews and revealed as a priority for the organization:

> *... if you ever look at Northern Health's strategic plan, one of its four pillars is to promote population health which is really unique. I don't know what it is like in the other places but certainly [the plan] places quite a lot of emphasis on looking at upstream kind of developments. I think that is what makes this quite a nice environment from a public health perspective to work in*. (BC participant D)

A population health priority evolved over the first 10 years of NH, and its rise to being an organizational-wide priority holds meaningful implications for NH programs, priorities and resource allocation decisions. Figure 4.1 presents a summary of the

population health strategic direction presented in the NH Strategic Planning booklet. The organization asserts that to carry out its mission of providing exceptional healthcare and improving health, it must place a priority on population health/health promotion. The connection between the two dimensions is seldom stated explicitly in healthcare organizational documents as is evidenced by a review of strategic plans for other RHAs in BC.[12] It is based on the logic that healthier people mean fewer patients, which means stronger resource allocation for those who do need care.

[12] A review of the strategic plans or statements of the other four RHAs in BC reveal that none of the other state population health as a strategic priority. There are encouraging comments about setting a priority to 'support health and well-being' or 'promote better health for our communities' and the like, but no express strategic priority for population health and the health-promoting activity it entails.

Figure 4.1: Excerpt from Northern Health Strategic Plan, 2009-2015

Also, as presented in Figure 4.1, Northern Health states that its population health initiatives are based on working with communities "to identify and act on key issues where a population health approach can have a significant positive impact on the health of Northern people" (NH, 2009). They also indicate they will work in partnership with key groups and use population health evidence to influence future resource allocation decisions (NH, 2009). This approach follows a more classic population health avenue in which: "…the most effective and sustainable public health interventions have been

characterized by high levels of community, organizational and political support" (Nutbeam and Wise, 2009, p.1663).

In sum, as cited by Participant H and the documents above, NH encourages community and population health in its organization through balanced outreach, including listening and integrating community concerns. This inclusion is manifested through direct meetings and interactions with individuals in contrast to working through intermediaries such as local boards or representative councils as with the initial implementation of BC regionalization in the 1980s.

In the next section, place-making in NH is contrasted with the analysis that emerges from the Ontario key informants interviews and NWLHIN corporate documents.

4.3.2 Northwest Local Health Integration Network

In the interviews with Ontario's LHIN representatives, the belief surfaced that the province's approach to gradual development of LHINs is a major restriction on the full potential of regionalization in Ontario (ON Participants A and C). The interviews also reveal that the actions taken by management within the current decision space are also very important in defining the relationships with health-promoting activities. In Ontario, community interaction by the RHA is an important component of its operation similar to the BC case. However, as is shown below, the interviews reveal relationships with intermediary organizations and an evident focus on population groups across the region that mitigate *against* efforts towards the development of a sense of place, and the kind of place-making that is more evident in BC.

The LHIN's corporate documents are similar to NH in that they stress the health and wellness of the population served. It's mandate, however, is to work with

organizations, and it does not provide direct patient care. Priority is placed on improved coordination among a variety of health service providers. This frequently involves dealing with organizational silos where independent actions from several organizations can conflict if a proposed collaboration results in opposing priorities:

> *…the first and foremost thing, I think, to me that is important is the level of influence that we can have in building the relationships and the capacity between the providers. Then let me qualify that because it is about – we have often worked in silos and thought we planned for the system and I think it has become more evident, as I have been in this role, that we [health providers] continue to work in silos planning for what we thought was a system, but taking care of the silo. So what I have really seen transition here, and it has taken a long time, [is] the willingness at the table to actually maybe join hands and start to work together because it is always still trying to work within the framework of the organization and institution first, even though we talk about the patient as the primary piece of it.* (Ontario participant C)

In Ontario, LHIN relationships around community engagement are greatly influenced by the pervasive presence of the extant local boards. Two different comments refer to the complexity and nature of local community engagement:

> *… and, of course, Ontario's model has been to keep the individual board run, community board run, corporations intact. And organized with coordinating networks call LHINs where we use some level of legislative authority along with the fundamental relationship building, and so on, to try to coordinate these individual stand-alone corporations [into] some sort of coordinated system.*
>
> *Let me talk about challenges because as you know in Ontario all the boards have continued to remain with all the health service providers, so in the northwest we have 106 service providers which means we have 106 boards of directors. That is challenging. I believe in the local voice. I think the local voice needs to be there, but we also know that we have some very small organizations who are going to be very challenged in the future with trying to implement the Excellent Care for All [Act], the requirements under the quality, the requirements under reporting, the accountability agreements, what they have to do in terms of getting documents in to us. Making sure the reporting is there.* (Ontario participant B)

Compounding the numbers of boards there is a difference in relationship building between the LHINs and the boards.

> *I can tell you that going out and doing our community engagement we heard from providers that they're doing a great job. Then we had public forums in the same community and found out from the public that actually they don't even know who the providers are in their community. And that if they go to one provider they feel that they get really good care so it's not that they are not getting good care when they get there, the issue is how do we get there? Who do we know to go to? We can't move from one to the other without our own difficulties.*
>
> *When we took that information back to the providers they were quite resistant. Now, [five years later] we have providers that are coming to us now and saying, "we need to do a better job of working together' because they now are doing community engagement and they are finding out from the people that they are talking to that their people are having trouble accessing service between and among the [health service provider] partners.* (Ontario participant A)

In terms of the place-making framework, the development of 'socially negotiated' place-frames between the LHINs and the communities' health needs are influenced by the intermediary local board that frames the concerns, perceptions and needs of the local community. While this appears to be interpreted by the local boards to be an appropriate facilitating role, the result is the LHIN is distanced from understanding the issues as perceived (and bundled) by community members.

As evidenced by the following interview excerpt there seem to be impediments to developing a sense of place among population groups. In fact, as the following excerpt illustrates, community engagement appears to ask people to literally leave place behind, even groups defined by place such as *on-reserve* or *off-reserve*, in order to discuss health in neutral *regional* environment terms. The approaches taken in Ontario then seem to frustrate the elements of the place-making framework outlined in Pierce, et al (2011):

> *We really are in a unique position compared to the rest of the province of Ontario because we serve the people that live here with most of the health care services. What I can say is that the value that I see of the regionalization, particularly to our region is that for the very first time there is improved coordination; people are now coming to tables to have conversations about health care. For example, in 2007 we held the very first Aboriginal Health Forum in the northwest where we*

> *brought together on-reserve First Nations, off-reserve First Nations, Metis, Inuit all together to a forum where we had almost 200 people – Chiefs, frontline workers, health directors and we were told by that group that they had never been at a table like this before to talk about health care, ever. The whole premise of the network or regional model in my view is that there are huge opportunities to be able to work effectively together, but the outcome is that we're really patient focused versus organizational focused.* (Ontario Participant A)

Ontario's LHINs have a mandate to engage the community and to coordinate health service providers to develop a more effective system that better meets the health and healthcare needs of the population. The continued emphasis on multiple boards of funded health service providers, as well as municipally governed public health units, influences if not restricts, the process of community engagement here making a true population health picture difficult to craft simply and directly because it is filtered through the many individual board priorities. Yet, conflicting organizational roles and overlapping corporate visions are the primary hurdles that require coordination by the LHIN. This landscape of overlapping governance responsibility detracts from and frustrates progress in building regional place-frames and encouraging place-making.

Further, there are impediments to place-making when geographic boundaries of regions are not aligned with other health providing organizations, particularly public health as in the case of Ontario. So aside from dealing with layered governance, LHINs must also work within an environment where a patchwork of public health regions have accountability for regions whose boundaries do not align with LHIN boundaries. To illustrate, the geographic expanse of the NWLHIN encompasses two public health units. In another example, a single LHIN in the vicinity of Toronto is responsible for an area that includes all or parts of five public health units. This fragmented landscape of health

services frustrates the development of a common vision among partners around health-promoting activities.

While in BC, NH conveys a picture of effort going in to place-making, the relationships in Ontario are more evocative of the concept of placelessness put forth by Relph (1976) as a corollary to his discussion of place. In defining placelessness, Relph identifies processes of mass communication, mass culture and central authority that bring about the standardization of landscape, and counteract the development of the meaning of place for an individual whether local, regional or global. While much has changed in terms of mass communication and mass culture since Relph's postulations, it has been argued that place independence is difficult. Cresswell (2004) suggests that in spite of the societal changes since Relph (1976) the role of central authority influencing placelessness likely perpetuates. Importantly, Relph's characterization of place-making and of the processes that result in placelessness can be created by individuals or groups either deliberately or without conscious intent.

While Ontario's regionalization model and some community interactions by the LHINs are seen to frustrate place-making and, accordingly, to limit more effective relationships around health-promoting activities, there is no indication from the interviews that this is a deliberate strategy of limiting the LHINs capacity. Rather, the LHINs' focus on centrally-mandated efficiency and other energies that foster placelessness appears to countervail any place-making action within Ontario RHAs (Relph, 1976).

The principal corporate documents (strategic plan, annual reports) of the NWLHIN further add to the dominant story of place-making as one of a struggle that

emerges from the interview data. Figure 4.2 outlines a perspective of population health that is vastly different from that of BC's Northern Health. In the NWLHIN strategic planning document, the listed population health initiatives are focused on provincial priorities, including reducing patient waiting times for alternate levels of care, provincial mental health, the Ontario diabetes strategy and the eHealth strategy. Only after these four centrally set provincial priorities are addressed as the major focus for population health, does the document allow for local priorities to be identified. These population health priorities reflect NWLHIN's position as an instrument in the province-wide approach to improving the healthcare system first and foremost.

These provincial priorities do not represent typical population health or health-promoting activities (e.g., programs related to alcohol, tobacco, immunization and or even matters associated with the broader determinants of health) as are often outlined in the literature (e.g., Nutbeam and Wise (2009) or MacLean et al (2005)). It appears that its use of *population health* is misapplication of the term to bring priority to province-wide healthcare concerns rather than local health concerns. The plan reflects a strategy for the Province of Ontario, and not necessarily for that of the NWLHIN health strategy. This point is underscored by the strategic plan of the NWLHIN, which does not mention working with either of the two local public health units in any capacity according to the strategic documentation delineating NWLHIN's approach to population health.

This differences between the NWLHIN and NH approach to population health reflects many of the fundamental legislative differences between the two provinces as outlined in the introduction to this section. However, it appears that the NWLHIN documentation re-defines or misapplies population health principles. With a mission and

purpose aimed at "the health and wellness of the people of the North West LHIN" and a vision of "healthier people," it would be expected by most observers that its strategic plan should include a stronger focus on local health-promoting activity whether encouraged through the organizations that are funded, or as a priority to work with the extant public health units.

Figure 4.2: Excerpt from NWLHIN Strategic Plan

High Level Outcomes

In collaboration with our health system partners, the North West Local Health Integration Network (North West LHIN) exists to achieve:

A. Population Health

1. Improved health outcomes resulting in healthier people.
    1.1 There is a major focus on provincial priorities:
        a. Through the Emergency Room/Alternate Level of Care (ER/ALC) Strategy, emergency wait times are reduced and people receive the right level of care.
        b. Through the Provincial Mental Health and Addictions Strategy, services will be evidence-based and provide opportunities for health development and recovery.
        c. Through the Ontario Diabetes Strategy, people will have improved access to services to manage their care.
        d. Through adoption and implementation of the eHealth strategy, health information will be more accessible and coordinated enhancing safety, decision-making and patient satisfaction.

1.2 Local priorities are identified and targeted through the North West LHIN's Integrated Services Plan (IHSP).

Source: NWLHIN (2009), p. 3

4.4 Why Place-making?

The principal corporate documents of NH and NWLHIN appear to offer many similarities yet close examination brings out key differences in their relationship to health-promoting activities. Both RHAs include a vast, northern geography in terms of square kilometres of territory, with a relatively sparse population that also has a high percentage who are aboriginal. In both cases, overall health status is poorer and the prevalence of accident and injury is higher than provincial averages (NH, 2009; NWLIN, 2009). At first glance their mission and vision statements are similar and reflect goals of top quality care, improved access, notions of a system of health services and improved health for the population served. Both organizations have strategic plans that call for *population health* as strategic direction. Closer examination of this important point of health-promoting activities, however, reveals meaningful differences between the RHA approaches and definitions of population health.

The different approaches to population health lead to a broader analysis of how RHAs relate to their communities and populations. Notwithstanding the community engagement processes in NH and NWLHIN, when it comes to strategy and measuring success, the corporate documentation indicates there is a fundamental difference in information flow. The NWLHIN receives provincial strategies and works in a top-down fashion to focus on integrating these strategies into the health provider system to achieve outcomes; while the NH documents outline an approach that is bottom up, beginning with the community and addresses a population health need by considering the creation of programs and their influence future resource decisions. This latter approach embraces concepts of *place and place-making* in two ways. First, NH develops itself as a separate

place focused on its population, as opposed to an extension of common provincially determined programs. Second, by developing the region as place and emphasizing the development of programs that are local, and that have special and positive meaning to the population, it allows for the local population to potentially view the region as a place with meaning to each of them.

This development of place is also evident in the nomenclature. Ontario differs from BC in its branding language, i.e., the name Local Health Integration Network. The RHA headquartered in Thunder Bay is called the North West Local Health Integrated Network or North West LHIN. First, the name offers very little that is of descriptive and connective value for people. Northwest of what? The specialty or jargon words of *integrated* and *network* are difficult for organizations and individuals to relate to, especially when the acronym LHIN is used. In contrast, NH stands for *northern health,* which is reflective of a way to centralize and represent the northern vantage point in BC. The name of the NWLHIN appears to be alienating and is most likely disruptive of any sense of place, meaning or sense of belonging to a local place.

The language in the documents represents place-framing by the organizational actors within the RHAs. It is also useful to reflect on the interview findings in terms of the Pierce et al. (2011) heuristic of relational place-making outlined at the beginning of the chapter. Whether consciously or otherwise, the region as place is presented differently in each province. NH key informants frame their region-place as one dominated by relationships and responses around health-promoting activity to its constituent communities and individuals served. By virtue of its community engagements and programs, place-making in NH is important to the application of its

mission and the strategies to achieve its vision. As illustrated in several places throughout the findings presented above, place-making in NH is revealed particularly when viewed in contrast with elements present in the Ontario situation. Perhaps this is brought most poignantly to the forefront in determining that in spite of its mandate being defined by legislation, there is a compelling drive to frame the NH as being comprised of its communities and their needs. This is in contrast to framing the region and its actions as solely an administrator of central direction.

Relational place-making is a theme that is grounded in the data based on the arguments discussed above, however, a separate focused investigation of this one theme would likely yield fuller understanding and insights into the relationship. At this point, the identification of the place-making relationship provides an initial understanding of how RHAs relate to health-promoting activity. There are other suggestions from the literature and the findings that suggest that relational place-making between regions and communities facilitates understanding and identification of the determinants of local health (NH Road Health, NH Oil and Gas population health) which are key elements in the development of an effective infrastructure for public health interventions (Nutbeam & Wise, 2009).

Two other themes from the data, *creating space within the organization* and *developing networks* are identified in the next chapter as key elements of the relationships between the province and RHA regarding health-promoting ideas, and, as is argued later, they also help to further explicate the dominant theme of place-making as it is developed here.

Chapter 5: Research Findings – Theme 2: Creating Space within the Organization and Theme 3: Developing Networks

5.1 Theme 2: Creating Space within the Organization (for Health-promoting Activity)

The relationships between a RHA and its mandated legislation define a RHA's decision space or *scope* of service as defined by Lomas (1997). However, the findings from the interviews indicate that what the RHA does with its authority and scope of service when considering health-promoting activity is also of great importance.

Theme 2 is grounded in the data and addresses the way that relationships can create organizational space for the development of health-promoting activity. These relationships can be seen in NH with the Chief Medical Officer of Health being included as member of the senior management team in support of a population health perspective and participating in all major management decisions including resource allocation. Also, in the case of NH, the creation of a separate Population Health department encourages the ongoing, day-to-day development of a health-promoting influence throughout the organization.

These two examples illustrate how a RHA can enhance its ability to advance health-promoting activity by taking specific actions to create spaces within the organization for health-promoting activity to flourish. This is primarily using *space* in the sense that the organization creates opportunities for health-promotion but also can have represented with it a tangible physical space represented by people, offices and inclusion at the senior management table. In both the metaphoric and physical sense of

creating space in the organization, the interview findings also suggest that the converse is evident. A RHA can also frustrate health promotion or even disregard commonly held understandings of health-promoting activity. Again, an example, would be the attention given across all of Ontario to those patients awaiting alternate level of care (ALC). In the NWLHIN's list of population health priorities, a strategy to reduce the volume of ALC patient days was listed as a *population health* activity even though as noted earlier, population health refers to a range of health promotion, prevention, diagnostic, treatment and follow-up therapies and services (McKee et al., 2009; Young, 2004). The characterization of waitlist management as a principal component of population health is confusing, if not misleading.

The interview data provided both positive and negative examples of how relationships between RHAs at the levels of governance, senior management and management and also in the planning, budgeting and priority-setting processes create space for health-promoting activity. McLean et al. (2005) posit that an organization contributes to health promotion capacity-building interventions through its commitment, its culture, its resources and its structure. The data suggest that these four dimensions closely shape differentiation in the experiences of the two RHAs studied in this dissertation and their health-promoting approach and activities.

Differences exist in how the two RHAs are internally organized to undertake health-promoting activities. This second theme is built upon the recognized importance and deliberate creation of space within BC's Northern Health organization for health-promoting activities. The interviews reveal a RHA that has strategically created

deliberate space within its structure and program development for health-promoting activity.

In contrast, the restrictions of a limited mandate and extant public health organizations appear to have stalled similar action in the NWLHIN where relationships around health-promoting activity are mostly confined to joint planning and coordination with others. While this limited role may appear to be mandated by the legislation, it is useful to recall the corporate direction of the LHIN mission and vision that laid out priorities for population health and health-promoting directions.

Also, the legislation in BC does not demand that organizational space be created within NH. There is no legislated requirement for the involvement of the Chief Medical Officer to be part of senior management, or for a RHA to have a Population Health Department. The interviews reveal these spaces of influence and power within the organization have been created and developed at the direction of its governance and management leadership and sustained through programmatic success within the organization. Excerpts from the principal corporate documents and the findings from the interviews reveal the character of this theme of creating space within the organization.

NH has reached the point where board health-promoting activity has attained important strategic positioning. As outlined in the previous chapter, one of the four current corporate-wide strategies for NH is entitled, *A population health approach* and it states that:

> *Northern Health will lead initiatives that improve the health of the people we serve. We will: work with communities and organizational partners to identify and act on key issues where a population health approach can have significant impact on the health of Northern people. We will work in partnership with our staff and physicians to create initiatives that foster a safe, healthy, and*

> *environmentally responsible workplace. We will use population health evidence to inform health service planning and resource allocation* (NH, 2009).

During the interview process, without prompting, all senior management referred to the corporate strategic plan and the prominence of the population health strategy and the role of leadership:

> *Both [names removed] [offer] such strength at our executive. As we were having these discussions about the system change and all that, they were saying, "Where else can Population Health be an equal among the four strategic pillars. I know nowhere else I can sit at the executive table and effect change". [They] were always vocal about that.* (BC participant G.)

NH's road to having population health and health-promoting activity as a prominent strategic priority took several years to come to fruition and began with basic facts about the health of northern residents, garnered through its early support of a specific program, *Road Health*, that was targeted at reducing injury and traffic deaths on the northern BC roads.

> *So, to answer your question, essentially there was no encouragement around doing the road health project. It arose out of the basic community diagnosis process where you look at the data, which showed that people in Northern BC were between two and a half, and in some areas three times, as likely to die on the road. Then, if you look at the demographics of who actually gets killed on the road, it's people in the prime of their lives. Clearly you make the place - and the other feature of road crashes is that they are highly preventable. So, it just seemed like a natural for public health but there was no established program. I think there was an injury prevention unit in the province that was interested in injuries in sort of a generalized, semi-academic way, but there was no public health programming around it. So, by virtue of having a board in the north that was approachable, that was interested in actually looking at the health status and thinking about it in relation to health services, [a presentation was] made on just those statistics, and the board decided that we should be doing something about this. And so that was the impetus really. That was permission at the local level that we wouldn't have gotten from Victoria. We might have, who knows what we would have gotten from Victoria, but it wouldn't have been sort of a blanket approval to start partnering with other groups and agencies like we did.* (BC participant P)

The outcome of the road health project was positive and resulted in:

> *…a pronounced reduction in motor vehicle fatalities to men over the past five or six years and then realized, in retrospect, that essentially what we were doing is men's health promotion because so many of our participants were truck drivers and people representing industry and we had a really high percentage of males at our conferences and everything. So then we go onto this overall whole issue of male health and men's health. It's a major issue and it has really not been part of the traditional Public Health area of interest, or even health services areas of interest at all in Canada.* (BC participant P)

This movement from basic population health statistics to a road health project, to men's health and core organizational strategy was supported by strong leadership; by the allocation of corporate resources; and shaped by independence within the relationship with the central provincial government (BC participant P)

The leadership of the LHIN in Ontario characterizes its role in public health and health-promoting activities as follows:

> *The role of the LHIN [for public health], which is not under our responsibility, is we work collaboratively with them and, in fact, we've just been having some meetings between their board and the senior leadership of the two public health units that we have in the northwest. They've now asked that we meet quarterly so that we can do some joint planning. The other piece is when we're meeting with all fourteen LHINs, CEOs with the Ministry of Health and the Deputy Minister, the Minister for Health Promotion and Prevention sits at the table. So we get some really good opportunities to have dialogue and discussion about common issues so that we can start to look at some provincial strategies. … We are working on a provincial falls prevention program that will be a coordinated program between the LHIN and the Public Health with Public Health taking the lead.* (Ontario participant A)

When asked to speculate further about the nature of the relationship with Public Health, the planning and coordination role was reinforced.

> *I can tell you that if you talk to the two Public Health Units that are here, the LHIN has actually been very helpful to the Public Health Units on several fronts particularly with e-health initiatives and technology. Of course, we're driving that change as well, that's another piece we're trying to move toward the electronic health record by 2015. We have a project management office here. [A colleague] will probably talk a little bit about that and he has actually been*

helping the Public Health Units, both of them that we have in our LHIN, one more than the other and one is more receptive and wanting to work with us so that there is a lot more open door opportunities to do things. I would say the relationships are stronger between the LHIN and Public Health.

Have their relationships changed [with regionalization] between Public Health and the public health service providers? I would say probably not a lot. I would think it's still primarily infection control with hospitals and Public Health not really having a lot to do with the other service providers. There's work to be done in that area. (Ontario participant A)

Emerging from these excerpts of the interview data are two key observations. One relates to the fact that the individual governance of the RHA and public health organizations is clearly reflected in their day-to-day relationships with each other. Interactions between them are confined to degrees of planning and operational cooperation. It seems that the LHIN's path to understanding and acting upon identifiable public health challenges is routed exclusively through the extant public health organization. This maze-like pathway tends to restrict the way they can work together.

The other key observation relates to the strong central role still played by the province. The first mention of working together referred to province-wide meetings and coordination at a level that is too removed from community-driven needs. This was earlier illustrated in the discussion on population health priorities.

The working relationships that emerge between LHIN management and that of a Public Health Unit are illustrated in the following exchange:

Respondent: *[LHINs are] really only caring about primary care and of course, home care and that sort of thing. They're palliative care or home care, but what we have found at least with our LHIN is they have worked with – the 14 LHIN CEOs work with the Chief Medical Officer of Health in the province to come up with an integrated strategy on something that they can all work on together and they've chosen falls in the elderly, falls for seniors over 65 as a joint project between the LHINs and Public Health, and I'm actually attending a meeting on October 3rd and 4th and one of them is with all the LHIN CEOs all about these falls and about looking at how the Public*

Health system [gets involves] with primary prevention – we're primary prevention. The LHINs do prevention, but it's secondary. It's [our role to] try to stop people from getting diabetes. [LHINs] try to stop people with diabetes from getting sicker.

[The Province] is going through a whole other diabetes network with the same mandate that doesn't fall under the LHINs or Public Health. They're totally separate in the province of Ontario, too, and they have a hundred different units. There's like 12 or 14 of them in our area alone who fund secondary prevention foot care, nutrition counselling, physical activity counselling that doesn't fall under us or the LHIN. One of them – and I only know about this as of two weeks ago 'cause one of those groups has asked us to be their lead agency and to do their bookwork and administer them, but they're mostly administered by family health teams or hospitals, but it's a separate network. It has nothing to do with the LHIN, but the LHIN has a diabetes strategy, too, and so does our Public Health Unit, and they also get funded through the Ministry of Health for a separate diabetes initiative, as well, so. So it's all scattered all over the place.

Interviewer: *Okay, and the – what I'm also hearing is that with the LHIN – its total raison d'etre or motivation seems to be on efficiency measured by funding mechanisms … and you haven't seen any particular evidence that they are helping work with you on advancing the Board of Health mandate at all?*

Respondent: *Not right now. They are receptive to it and they have actually – they started up a project management office. We were the first adopters of it even though we don't belong to them or are funded by them, but we actually adopted their tools and we're actually following their protocols for implementing projects based on … it's actually on the Project Management Institute, but they actually have a project management office.*

Unfortunately for them, the hospitals in our area, from my perception, hate the LHIN. Politicians hate the LHIN. Everybody's so fixated on the salaries of the LHIN. My opinion is they exist, they're funded, it's taxpayers, we will work with them, so we have worked with them and we have tried some initiatives with them. They're right now trying to even rationalize – 'cause our dollars are peanuts compared to even a medium-sized hospital around our areas got a bigger budget than us. Now they're still trying to rationalize some of the escalating costs within those hospitals right now, trying to get them for purchasing and just trying to stay within their 1 1/2% budgets …

Our mandate for Public Health, we like to say, is to improve the health and life of our population. The real mandate for us is health-contained costs, working at the [level of] cost containment. We hope to be seeing a cost containment, so that's what – primary care looks at Public Health.

> *They want us to help cut down emergency room admissions. We just met with a hospital about this recently. They want us to come up with a plan to cut down their costs.* (Ontario participant K)

From this excerpt, it is clear that the relationships are being developed, but are being heavily driven by province-wide priorities, and with unclear and at times, overlapping responsibilities. Of particular note is the description of the diabetes strategies. The comments paint an unsettling view of the approach to diabetes with the above observation that the networks are not perceived to be working together and are "all scattered all over the place" (Ontario Participant K).

The above excerpt also recognizes that LHINs should be doing more with Public Health to develop health-promoting activity, yet the conversations seem to focus on provincial structures or co-operation in a few programming areas. The structural constraints are robust and management is unable to shape the organization around health-promoting activity in a meaningful way that would incorporate: strategy, structure and comprehensive programs as the following excerpt attests:

> *Public Health is separate and distinct not only from a structural standpoint, but also from a funding standpoint. So they receive their funding from…the Public Health Units I am talking about now, they receive their funding from the Province and from Municipalities. It is a percentage breakdown between those two organizations. It is just the way that LHINs were set up back when we were first established in 2006, but I think that as we go along the journey of the evolution of transforming the health care system, it is very clear that we need to have greater and closer alignment with Public Health. We have started to be more direct in terms of how we are acting with our Public Health partners. It will start at the Provincial level first I guess. The fourteen LHIN CEOs meet with the Ministry Leadership Group which would be the Deputy Minister, Assistant Deputy Ministers on a monthly basis. Arlene King is there as the Assistant Deputy Minister and Chief Medical Officer of Health to talk about how we can create greater alignment.*
>
> *So I think there is an agreement that we should be working more closely together and we have had a recent initiative around falls prevention, working with our Public Health Units and some of the geographies around the province where*

> *LHINs and Public Health Units have been working closely together in rolling that out, and LHINs have actually been providing funding to some of the Public Health Units to assist them in that falls prevention process because as you know falls [prevention] are a key contributor to hospitalizations for seniors and readmissions and all of the things that we are trying to prevent from the health care system …*
>
> *So I think everyone agrees that we should be more closely aligned. [Name removed] [Chief Medical Officer of Health for Ontario] and [the] report on H1N1 talked about the need to have greater alignment between the 36 Public Health Units and the roll out of a response to an emergency like H1N1. So[s/he] has got a report that was produced and talked about the need for some type of a regionalization and you are not going to get any argument from us that LHINs, or I think provincially as well that we need to have greater alignment, connection and coordination between the Public Health Units. There is quite a bit of variability between Pubic Health Units. Some have a full-time Medical Officer of Health that provides administrative and clinical leadership for the Health Unit whereas many of them, and particularly in the rural areas, that have a part time Medical Officer of Health who may be a family physician who plays the role of Medical Officer of Health for that region. So, the amount of interaction that that Health Unit has with the broader health care system, there is, I would say, great variability between the Health Units. We have several strong ones here in the [our] LHIN that we work very closely with. We try and ensure that they are closely aligned with what we are doing here and actually fit as part of our – we have a health leadership council, health assistant leadership council which is leaders from all of the different sectors across our geography and we have Public Health Units representation on that group. But those are the Health Units that have strong leadership and strong system outreach whereas the other ones that don't have that we don't have that high, high level of interaction that we should be having with Public Health Units.* (Ontario participant Q)

The relationships between the regional structure in Ontario and Public Health are limited by the layering of responsibilities among organizations. The layering of LHINs on a network of extant public health units, as well as the continuation of autonomous boards with control of hospitals and hundreds of other health service providers, has perpetuated a patchwork quilt of services that relies upon inter-organizational collaboration to foster health-promoting activities in any comprehensive manner. This results in a similarly fragmented and scattered decision space (also accountability) around

health-promoting activities, which gets further fragmented in a scalar way by the need to default to province-wide priority setting, rather than local needs. One of the most consistent examples of this is the falls prevention initiatives often cited in these interviews. In effect, this approach discourages comprehensive local, population health driven programs as part of health-promoting activities.

Excerpts from the Ontario data suggest it is unlikely that a road health program to reduce motor vehicle deaths such as the one spearheaded by NH in BC would surface in Ontario at this stage of the development of LHINs because the severity of the situation in the remote northern setting may not be sufficient to attract provincial priority for all LHINs.

5.2 Theme 3: Developing Networks: from Maze to Labyrinth

RHAs in the Canadian healthcare system provide services that are in many ways networked through linkages with government departments and agencies, with similar health and healthcare organizations and with allied health organizations. The interconnections can be simple, complex, or even confusing by being complicated. Sternberg (2009) offers an intriguing analogy that provides insights into health networks by differentiating between mazes and labyrinths. According to her, *maze-like* health system tends to confuse those accessing the system due to complicated corridors or misleading signals. In some circumstances these passageways and signs are literal such as patients being directed to *emergency* rooms when physicians are not available for *routine*, *non-urgent* doctor office consultation and, in others, they are metaphoric and representative of bungled referrals, duplicate testing and other confusing healthcare practices. Conversely, a *labyrinth,* while complex, is not complicated because there is

only one logical path from the outside in to the centre. Indeed, a true labyrinth is designed to calm and reassure. Based on this analogy, the research findings reveal the identification of a third theme linked to how relationships external to the organization can influence health-promoting activity within the RHA.

This theme of developing external network relationships around health-promoting activities for RHAs is recognizable and persistent in the interview data, however, it is difficult to characterize for two reasons. First, the RHAs of NH and NWLHIN both partner in health-promoting relationships with several different types of organizations: government, including ministries of health and public health; local branches of national organizations, such as the Canadian Cancer Society; and, others, such as local industry that coalesce around certain health and healthcare matters from time to time. As a result, there are no predetermined sets of external relationships for any organization and often, those that occur are often episodic around particular situations.

> *Well, there is a growing understanding about the importance of prevention - I think generally and I think that because Health Authorities are so wrapped up in their own worlds, even when you make approaches to partner with them from the community, it is hard for them to stay focused on doing that. Every so often an individual might come along in the Health Authority who is this way inclined but then they get maybe diverted to another portfolio, maybe they move onto something else. So it often is the exception of that particular individual. So I am not impressed, generally speaking, with Health Authorities and their partnering on prevention.* (BC participant R)

The second reason these network relationships are more difficult to characterize is the variability they exhibit in terms of direct expectations of accountability around the relationships. For example, there is no explicit accountability built into legislation or major funding agreements for a RHA to work with industry or local allied health organizations. Instead, building a more collaborative network is a voluntary action

driven by an internal strategy and leadership that brings with it a lack of clarity around roles within the relationships. Further, such opacity fosters informality with little accountability within many of these existing relationships. The previously cited meeting to address aboriginal health in northwest Ontario is an example.

The data presented for a variety of external organizations (government, other RHAs, allied health, industry) provide insights from both the Ontario and British Columbia cases that reveal the difficulties with systems that operate in a more maze-like fashion. This is the conventional view of many of the Canadian provincial health systems (Deber, 1996; Scheon et al., 2009). Such systems are often characterized as inter-organizational silos that counteract facilitating more integrated systems. Progress in breaking down silos occurs (such as the NH Road Health Program) because of RHA initiatives regardless of the legislative decision space and without provincial involvement.

This third theme considers the external relationships between the RHAs within the broader network of health and healthcare providers. The difficulties with developing external networks are similar in both RHAs. Ultimately, for both, the opportunity to develop a positive health-promoting agenda appears to be constrained regardless of the differences perceived in the previous themes. This suggests that the inertia from the forces of individual organizational culture and strategy, on balance, persist in creating a patchwork of service points hence, frustrating a more coordinated system of customer focused care:

> *It is a lack of consistency [across RHAs] and [lack of] attention is what cause, I think, a lot of the issues. … Once the traditional model of having a Medical*

> *Officer of Health as CEO of a Public Health Unit was disbanded what you saw was Public Health Nursing was only too keen to go off and run its own show very separately from the rest of Public Health. Public Health Inspectors were only to keen to go off and run their own show. So what you ended up with was Medical Officers basically doing communicable disease and health hazard assessment … often a big gulf between what the health inspectors were doing or what they ought to be doing or how they did it. And, a similar gulf around the Public Health Nursing side. So you have a lack of consistency of approach.* (BC participant L)

> *We have encouraged those [health-promoting] relationships in terms of planning, but there has never been any accountability and I think, as I said, even the fact that there was a separate Ministry even from our own planning perspective within, we didn't take as large a role in terms of the preventative aspects because there was another Ministry that had that mandate. I think Public Health remains a bit of an issue because there is also another government that is involved because of the structure of Public Health in Ontario. It is a very complex structure. There are a number of different governance structures so we are encouraging relationships.* (Ontario participant M)

The lack of consistency, coordination, cooperation and team work promotes the creation of independent operational units with identical mandates that erect fences that bar effective communication. The unintended outcomes produce health-promoting networks that are overly maze-like and difficult to navigate for users and providers. Perhaps the apogee of the maze that describes health-promoting relationships is exhibited by the absence of explicit connections between the RHA and community agencies such as the Canadian Cancer Society or Alzheimer Society.

> *Well, I would expect the relationships in each regional area to be a very positive relationship even though I have so much evidence to the contrary. I would say that generally speaking Regional Health Authorities are not good partners and it is not like they intend to be difficult. It is just they are not accustomed to collaborating and particularly with the NGO community*. (BC participant R).

> *Each of the agencies at the end of the day had difficultly committing energy and resources and staff outside of the envelope and I think there are legitimate reasons why that is true; but we worked with them. We had some good exchanges. We definitely recognized that we are on the same team. That has been a little bit more problematic to really, really be actively involved with them.* (BC participant P)

To develop a more labyrinthine network for health-promoting activities, RHAs and public health units may need to look at ways to serve similar populations and adjust or align their administrative boundaries. The following two excerpts demonstrate the frustration with non-alignment in different ways:

> *One of the challenges between the two is the boundary issue. So I think one of the reasons our Health Units and LHINs don't work well together is because one Health Unit can have five LHINs it has to deal with; while one LHIN can have five Health Units it has to deal with. So it gets very complex because they are all very independent …* (Ontario participant J)
>
> *… in an ideal world the boundaries would be contiguous [sic] between the health sector and the non-health sector so that you could work together. It's a huge problem, right? It's a massive problem. [There are] 36 Health Units. Toronto public health deals with five LHINs. I think it is five LHINs, it is either four or five.*
>
> *So, it is like the maps don't align, but more importantly, is that there is no alignment with the non-health sector boundaries either. So, if all of the boundaries align, so what do I think is the biggest problem that we have? It is that the boundaries don't line up, period, like they do in Quebec. They only have one boundary right? What a lovely world. I don't know how many [regions] is the right number, but the boundaries need to align between education and between health and between environment and between all of these various groups at the local level.*
>
> *How do you build relationships when there are just too many people to build relationships? I mean people are moving in and out constantly of that sector. By the time you've made a friend they are gone. It's true.*
>
> *Yes, exactly. I mean the networking is endless, not that networking is a bad thing, but you've got to do something other than network, right? You have to really be able to functionally work together, I mean actually work together to advance the agenda. That takes a lot of time and effort.* (Ontario participant O)

The findings suggest that all levels of management within the RHA, province and allied health organizations recognize a need for effective networking by RHAs in the conduct of health-promoting activities. There are successes around specific health-promoting activity projects (e.g., falls and road health), but the development of longer-

term strategic commitments (including programs focused at chronic diseases such as diabetes or efforts tackling the broader social determinants) are often frustrated. There is little evidence of lowered stress, and smooth linkages that would allow patients a clear path throughout their trajectories encompassing both preventive and curative processes. The relationship between RHAs and building effective networks is present, but in a fledgling way with little evidence of sustained success in either of the two research case regions.

5.3 Overview of the Findings

The three themes discussed in this and the preceding chapter are developed from the interpretive analysis of data grounded in key informant interviews and corporate documents of each RHA. These themes provide a deeper understanding of the relationships between RHAs and health-promoting activity. The three themes of place-making, creating space within the organization and developing networks represent a framework for better understanding the relationships between RHAs and health-promoting activity.

Place-making is emphasized as a leading or primary theme for developing an understanding of the potential for the *region* to facilitate health-promoting activity, especially where the mandates for public health are integrated with the mandates for other aspects of the health agenda (e.g., health service provision).

The second theme of creating space suggests that legislative scope of service is only one part of health-promoting activity. In this research, the data indicate that what an organization does with the mandate is critical. Creating space within an organization for population health/health-promoting activity needs to be based on strategic priority

setting, proper resourcing and clear communication. While on the surface it may appear to be a component of the dominant theme, a *creating space* theme merits separate identification because of the way this theme plays out within the organization (i.e., internally, whereas the influence of the other two is external).

The third theme revealed in this research is the importance and need for sustainable networking between all of the organizations involved in order to foster health promotion and the provision of healthcare. Although the theme of networking is evident, the findings from this research suggest much networking is constrained by unclear relationships and an absence of accountability. Networking flourishes occasionally within time-limited projects and focused attention, and lays idle at most times.

Chapter 6 ties these three themes back to the overarching research questions and discusses their overall relationships with RHAs through the theory-building dimension of this research.

Chapter 6: Discussion and Conclusions

The purpose of this chapter is to discuss how this dissertation addresses the research questions and to present conclusions. The following section reports on each of the three research questions and presents the theory of therapeutic regions. The next section specifies conclusions drawn from this work and then discusses the implications of the conclusions for RHAs. Particular attention is paid to policy implications for future health system regionalization in Canada. The conclusions are followed by reflections on the limitations of this work, and a final closing section outlines possible future research.

6.1 Relationships between Regionalization and Health-promoting Activity

The initial research questions were:

1. What is the nature of the relationship between regionalization and health-promoting activity?
2. How does regionalization influence health-promoting activity?
3. How do theoretical constructs help in understanding regionalization and, more importantly, the relationships between place and health? Conversely, how does the understanding of these relationships help build theory regarding therapeutic regions?

Research Question 1

In this dissertation two characteristics of the relationship between regionalization and health-promoting activity are identified from the two RHAs that were studied. First the fundamental relationships formed by whether or not there is health-promoting accountability directly in the RHA mandate must be considered. However, even within a

provincial setting where the mandate is present and similar for all RHAs within that provincial setting, questions arise about what the organization *does* with its public health mandate. The public health mandate can be developed within a regional structure because of the advantage of local scale and of local attention to health-promoting activity. RHA strategy can include a meaningful emphasis on the policy stream that emphasizes health-promoting activity.

Second, overall the relationship between regionalization and health-promoting activity appears to remain subordinate to a strong historical relationship between regionalization and healthcare cost mitigation. The literature details that in Canada, decentralization has historically been used as an approach to rationalize healthcare systems. However, this research suggests that there is also a potentially strong relationship between regionalization and the advancement of health-promoting activity in the cases studied here.

The relationships between regionalization and health-promoting activity in British Columbia are founded on a mandate that is legislated by the province and reinforced through personal relationships among board members, managers, and individuals in the communities. Further, as recorded in the findings, the relationships do not emerge instantaneously; they are seen to evolve. For example, in the case of NH, it took two strategic planning cycles, or nearly 10 years, for a population health agenda to be fully incorporated as one of its four strategic priorities.

Research Question 2: *How does regionalization influence health-promoting activity?*

A regional administration where health-promotion is a priority focuses attention on the health status of the population served, allowing organizations to embark upon population health projects and to move beyond community consultation or periodic engagement with what is characterized here as *place-making*. While this may appear to be logically and self-evident, it is worth underscoring the point that working at a regional scale permits organizations to attend to various social determinants of health and other strategic levers that influence health decision-making such as social justice or spaces of risk. Management working in independent hospitals or community health centres would be less likely to concentrate on the broader scale of a regional perspective because their mission and vision are local.

There is specific insight into how health-promoting activity influences the region. The investigation into the relationships between RHAs and health-promoting activity expands upon the geographic concept of therapeutic landscapes. A case is made in this dissertation to consider a health region as a 'therapeutic region', a place that is administratively conceived and responsible for imbuing health and healing through a blended approach of health-promoting activity and curative healthcare. The findings suggest this occurs when a RHA has a strategic priority on population health and health-promoting activity, invests in its people, and fosters the development of a sense of place about the region.

On the other hand, there have been several observations in this research that lead to a view that regionalization could frustrate health-promoting activities. This perspective begins with the centralization paradox where regions attain *decision space*

from the provincial authority that at the same time strips autonomy from local agencies (i.e., elimination of local hospital or social service boards/organizations). In such a circumstance diminished local autonomy may make it more difficult to successfully implement local public health interventions.

Research Question 3. *How do existing theories help in understanding regionalization and, more importantly, the relationships between place and health? Further, how does the understanding of these relationships reveal theory regarding regionalization and health promoting activity?*

This dissertation addresses question 3 in two ways. First, in Section 2.1.3 theories of local autonomy and territoriality and a body of literature on regionalization set a context for this work. Second, this dissertation develops in section 6.2 a theory of therapeutic regions that proposes interaction between place-making and strategic commitment to health-promoting activities (within the organization and its networks). A therapeutic region involves a strong sense of the region as place and a commitment to creating space within an organization for health-promoting staff and ideas to flourish. It means working with network partners and using RHA assets and capabilities for promoting health, lowering stress and improving access to programs and services for individuals. In order to link the two ways this question has been addressed, Section 6.3 draws links between the theory and the literature that was discussed previously (Section 2.1.3).

6.2 A Theory of Therapeutic Regions

The three themes that emerged from this research individually represent a relationship between the RHA and health-promoting activity, however, the three themes

themselves should not be seen as being completely independent from each another, but as reinforcing.

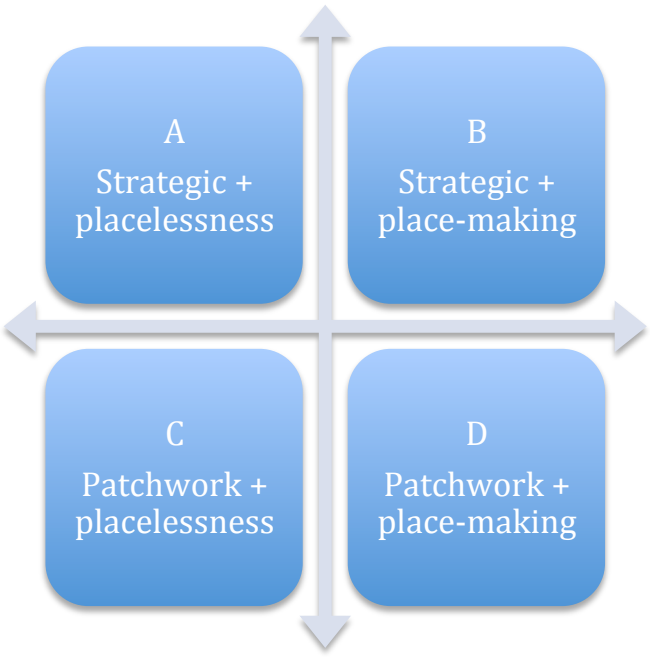
Place-making involves more than the transformation of relationships with the communities and the populations served. While it does involve developing the relationships with communities in a fashion that brings special meaning to the region as a place of and for health, it does not stand alone in this regard. For example, as was outlined in the report of NH's Road Health initiative, the place-making aspect of that project also involved significant network development and was built by the capabilities of the individuals who have health-promoting agency within the RHA (Bowering, 2005). This manifested in several ways: the Medical Officer of Health being included in the senior management team; the creation of a population health department; the board establishing a population health strategy; and with senior management providing leadership and support.

Creating space within the organization for health-promoting activity supports *place-making* between the RHA and community and also fulfills a role within the organization itself in terms of support for strategic thinking, budgeting and influencing individuals. It is a theme that allows the RHA to develop capacity to reach individuals, including those who are vulnerable, as well as those in need of care within the organization such as caregivers and managers themselves. NH's population health department's characterization of its activity reinforces this view. The most important manifestation of the critical contribution of the *creating space* theme is the example of the inclusion of population health as one of the four principal strategies of the organization (NH, 2014).

Theme three, *developing networks,* is affiliated with *place-making*, yet also exerts its own relationships on health-promoting activities. While the previous *creating space* theme involves reaching *down and within* the organization to support place-making and health-promoting activity relationships, the *developing networks* theme is viewed as a theme that reaches *up* and *out* (i.e., externally) to individuals and other organizations, including central health authorities, such as provincial cancer programs.

To provide a platform for further discussion, Figure 6.1 presents a framework drawing on interpretation from the interview data and documents. This four quadrant matrix outlines the meaning and connections among the themes as they relate to the theory of therapeutic regions.

Figure 6.1: The Theory of Therapeutic Regions



The horizontal (right-left) axis represents a continuum between placelessness on the left (A and C) and place-making (B and D) on the right. *Placelessness* is the abstract concept that Relph (1976) saw arising from mass communication, mass culture and central authority. Whereas, the right-hand side of the continuum represents the existence of a relational sense of *place-making*. Place-making refers to health-promoting activity and healthcare services that are seen to be readily accessible in all places and where a RHA develops its region as place so an individual's place is defined by the availability of those services. Place is 'at work' in the right hand portions of the horizontal continuum.

The vertical (top to bottom) axis reflects a continuum of the nature of a range of decisions and actions taken by an organization. At the top (A and B quadrants) organizations are characterized as taking strategic decisions in regard to health-promoting activity. In the lower portion of the continuum (C and D) decision making is viewed as being disparate, piecemeal or patchwork with regard to health-promoting activities.

This matrix reflects several relationships linked to the *creating space* theme. This includes how a RHA responds to its legislated decision space, and what the RHA does with that decision space for health-promoting activity. For example, the vertical axis reflects how a RHA interprets its mandate, or lack of mandate, for health-promoting activity, and incorporates it or doesn't, into its overall strategy. The axis reflects whether a RHA only reacts and implements piecemeal directions from the province (toward the bottom of the vertical axis) or advances its role in health-promoting activity into one of its core strategies (top of vertical axis).

The remaining organization theme represented in the matrix is *network development*. Actions that result in a patchwork and maze-like networks are part of the

dimensions represented on the bottom range of the vertical axis. In contrast, more strategic and assured access to services is represented at the upper reaches of the vertical axis. The gradation from bottom to top also reflects theories of how organizations change and the continuum by which organizations work together from loosely aligned networks to fully collaborative systems (Nutbeam et al., 2009).

Finally, this vertical dimension can be seen as an amalgam of relationships between a RHA and the two streams of pervasive health policy in Canada. Whereas curative healthcare (doctors and hospitals only) dominates in the lower portions of the continuum (patchwork and maze-like), both healthcare and health-promoting activity are seen to be priorities of organizations at the other extreme of the continuum.

When linked together the themes and their relationships frame the theory of the therapeutic region. The matrix represents various stages and combinations of actions/processes among different axes where place-making, creating space within the organization and networking occur. Each quadrant is discussed below.

The lower left quadrant C depicts a relationship that describes RHAs whose services/service providers are operating independently; where there is still a fair degree of central control over priority setting; and where any health-promoting activity typically involves one-off projects conducted at a small scale that is dwarfed by conventional healthcare in terms of volume, budget and strategic priority. RHAs see breaking down silos as a principal need in order to make progress on health-promoting activity. Networks are characterized by system duplication, referral dead-ends and uncertainty as in Sternberg's (2009) maze.

The upper left quadrant A characterizes a blend of relationships that would see RHAs establish working relationships with other organizations to advance health-promoting activity, thereby heading toward the beneficial outcomes of such efforts as opposed to only undertaking centrally mandated actions. In this quadrant, there is still a question among such regional organizations as to the need to pay attention to health-promotion within the region. The regions are defined more by their boundaries and space (area) than by their social networks, health determinants and sense of place. As conceptualized, a balance surfaces in this quadrant between activities that address both the curative and preventative health policy stream. However in this quadrant, health-promoting activity is driven by general and non-place specific demographics where demographic groups define programs, for example women's health, without a particular regard for place. This aspatial approach surfaces in the research results where, in the Ontario experience, centrally defined programs such as falls prevention and First Nations' healthcare are cited as the focus for health-promoting activity. This program activity is carried out seemingly without adequate attention to place and particular local needs. The role of the central authorities in priority setting for the region remains strong and the opportunity for local program innovation is restricted.

The lower right quadrant D represents a blend of activities addressing the curative and preventive policy objectives. In this quadrant, there is recognition of the importance of place, but with continued patchwork project oriented health-promoting activity influenced by external central authority. Regions in this quadrant can be seen as having worked at forming constructive working relationships with other organizations, with protocols that more closely align with Sternberg's (2009) metaphoric labyrinth. Program

activities respect and are meaningful for the population who participate, and the RHA is viewed as being a leader in developing healthy populations, healthy individuals and healthy communities. It is conjectured that risk could arise for RHAs in this quadrant if they respond to a perceived need without consideration of adequate resources or patient volumes to justify a particular service (*critical mass*). Legislation, budget and provincially mandated priorities and lack of meaningful involvement from public health leadership are factors that hold these RHAs back from moving to the top right quadrant B where the themes fully converge.

A strong sense of place and an internally driven, outcome focused agenda, aimed at both promoting health and providing quality healthcare, characterize the upper right quadrant B. This is the quadrant where the administrative structure and processes allow for a RHA to effectively advance health-promoting activities. In this schematic, this is the 'ideal' quadrant and represents the most successful therapeutic regions.

RHAs in the upper right quadrant "find place at work" (Casey, 1997) meaning that the region's actions shape perceptions of place and are shaped by the places it serves. Based on this research and the insights offered through the literature, a RHA in this quadrant could be characterized as considering local health status, analyzing local needs and having programs that reflect particular attributes of the population and communities served. Programs are developed and evaluated based on local expectations for improved health status, often by focusing on the most vulnerable or promoting the continued good health of major cohorts (e.g., First Nations, drivers, youth, etc.).

With place at work, the population served views health-promoting activity as a locally sensitized community service that brings special meaning to them as individuals

regardless of their particular social or health status. The RHA is viewed less as an organization (especially a regional or provincial one), and more as people responding to the health needs in the community. The RHA is known for its services and programs, and its advice and guidance to individuals and populations looking to improve and maintain health.

Further, while all services are not available in each community, the first place of contact is an assured portal care and treatment. Services delivered remain customized to the needs of various communities within the region. Accordingly, the network of actual service delivery points may be complex, but there are clear and certain (labyrinthine) paths to the health services, as well as to those services that relate to health (social determinants of health). This allows the RHA to offer an environment in which individuals, populations and communities find meaning and empowerment. The scale of the region is small enough to appreciate local needs and priorities, yet large enough to offer a wide range of programs locally and respond to a number of the social determinants of health. The region can listen, observe, program, budget, measure and evaluate an array of programs and services that respond well to local needs. Regular assessment and measurement of health status by a RHA unifies the curative and preventative policy streams from executing conflicting actions. Instead programs and decision making are guided by a single clear organizational priority of improved health status.

Also, in the upper right quadrant B the central authorities fulfill the role of developing best practice benchmarks for a full range of health services. For example, they facilitate access to the highest order health services that are not possible to deliver at

a regional level such as advanced and specialized cancer care or cardiac surgeries. Further, they steward policies and budgets that are available to ensure equity to universal access across the province and measure RHA performance and share such information without conditions. The central authorities avoid forcing provincial priorities on to local RHAs. By doing so, the provincial mandate acts as a catalyst to allow place-based concerns to be addressed, rather than to constrain local initiative around health-promoting activities.

The convergence of all three themes in the upper right quadrant B is important to the idea of the therapeutic region. While numerous philosophers have written about conceptualizations of space and place (Casey, 1997; Lefebvre, 1991; Foucault, 2000), the relationships put forth by Deleuze and Guattari (1987) offer insights into the place-making that is possible for a therapeutic region when the concept of place is used to characterize *place-as-region* (Casey, 1997).

Deleuze and Guattari (1987) do not see a region being contained or comprised of places, rather in their conceptualization, the region itself is a place: "The region is the place I am in. Thus the absolute [the region], becomes the local, rather than the reverse. For *place itself is everywhere* – everywhere in, indeed *as* the region" (Casey, 1997, p. 305). This view of the region can be closely linked to the conceptualization of place-making in the therapeutic region – where the meaningfulness of the locale becomes the meaningfulness of the region.

Moreover, the proposition put forth by Deleuze and Guattari (1987) also brings forth the idea of *immersion in a region,* a concept that sees regionalization working … "not from exteriority to interiority, but the other way around. The "being within" yields

to being *without*. Immersion in a nomadic smooth space [i.e., unbounded, undifferentiated space] is immersion in something more vast …" (Casey, 1997, p. 306). To elaborate, this notion of *region as place* is akin to being immersed in "something more vast," and reifies the theory of the therapeutic region by providing understanding of its local operations. In essence, a therapeutic region inculcates a sense that the RHA provides, represents or is the critical link to all services in all places whether or not the service is physically provided in a site in the community. This does not mean that the RHA is all things to all people, but that it can lead those in need through an assured path to all required health programs and services without dead-ends, or unnecessary duplication. Even higher order medical care provided at a distance is considered part of local care because the RHA is the place where the service is initiated.

This theoretical framework helps with understanding progress on regionalization in Canada to date. All modern regionalization started in the lower left quadrant C where attention on administrative control of costs and integration are dominant. It is suggested that as some RHAs rolled out their programs they responded to either a greater sense of place (a move to the right on the horizontal continuum), or a more strategic approach to integrating health-promoting activities (move upward). As RHAs moved from their original positioning in the matrix, it was perceived that there was a corresponding challenge to central authority. The RHA was perceived as either stretching its scope or mandate as it responded to local need along the horizontal axis. Or, the RHA was perceived as too bureaucratic as it added staff and was seen as duplicating capacity within central authorities. The response to these changes led to phases of (re)consolidation

outlined in Chapter 2. Other RHAs are perceived as having moved from the lower left quadrant C, such as British Columbia.

Northern Health took a couple of strategic planning cycles, or approximately ten years, to get to where it is now with its greater sense of place-making, more internal health-promoting capacity, and its networking accomplishments with programs such as road health and men's health. It can be seen as having moved over its first decade from the lower left quadrant C toward the upper right quadrant B with more or less a concave trajectory.

In Ontario, the NWLHIN may have shifted upward somewhat from the lower left quadrant C toward quadrant A, yet there are constraints on significant movement to the right side of the framework exerted by the extant organizations and boards and the need to work through others before any semblance of place-making is possible. From the perspectives of governance, strategic priority setting and administration then, the NWLHIN is on a more challenging path in terms of delivering on its mission and/or getting closer to its population health vision.

A therapeutic RHA focuses on continual improvements in its populations' health status by supporting place-making, ensuring strong internal health-promoting capacity and enhanced access for all segments of the population through pathways that are non-stressful (for patients and providers) and coherent.

6.3 Theory of Therapeutic Regions in the Context of the Literature

Further understanding of the relationships and the conceptualization of the theory of therapeutic regions can be gained in reference to the existing literature that was cited in earlier chapters. This section will reflect upon the literature of therapeutic landscapes,

the models in the literature on health service decentralization, and the theories or sensitizing concepts of local autonomy, territoriality and structuration theory.

Williams (2007) puts forth an idea that most literature on therapeutic landscapes relates to *natural* and *built* landscapes. Built landscapes refer to physical structures, such as hospitals or rehabilitation centres that are seen to be therapeutic, or that can also refer to 'run down' neighbourhoods that are detrimental to health (non-therapeutic). In this research, the theory of therapeutic [health] regions was tied to the concept of therapeutic landscapes as developed within geography. As a form of therapeutic landscape that is neither built nor natural, regional health authorities can be considered to be *therapeutic regions,* and taking this position can provide insights into *administrative* areas and their degrees of agency.

A therapeutic region also responds to ideas drawing upon Curtis' spaces of risk and other elements of social justice. By advancing health-promoting activity as part of its corporate mission and strategic plan, a therapeutic RHA would have a commitment and the flexibility to address how "different combinations of health determinants [come] together in different ways" to create spaces of risk (Curtis, 2004, p.6). A therapeutic RHA then is not only distinguished by having a mandate that would include both preventive and curative care, but particularly because of its place-making orientation. This orientation supports a place specific understanding of the needs of the populations served. A population driven perspective, and responsiveness to spaces of risk also reflects the therapeutic region's attention to social justice through its inclusion of a clear focus on effective public health activities (Bonta & Cagle, 2009).

The cited literature on regionalization and decentralization also provides a helpful lens for the theory of therapeutic regions. The various stages of decentralization characterized by Mills (1990) outlined models as discrete arrangements: de-concentrated, delegated, devolved and privatized. The suggestion that healthcare may be delegated while health-promoting activity can result in more of a devolved relationship sheds additional light on their original work. This notion of shifting and overlapping models of decentralization can be coupled with findings from Mitchell and Bossert (2010) pertaining to the study of health systems in several countries. These authors suggest that a balance between centralized and local authority is usually related to better performance. It is possible that a flexible model of decentralization that balances local and central power differently for different programs or different regions may yield stronger performances on both the curative and health-promoting policy agendas. But, should all regions within a province have the same mandate? Or, should all program areas within an RHA have the same *decision space*?

Further insights into this question as to whether all regions should be structured similarly within a province are offered by the previously cited theory of local autonomy Clark (1984) and Sack's (1983) theory of territoriality. Territoriality is prevalent in regionalization schemes where the control from the centre is strong. Control is expressed in terms of a centre's ability to legislate mandates, appoint key personnel to governance, and manage regions and specify program priorities. In the theory of therapeutic regions, it is implied that as regions exercise more local autonomy and initiative (e.g., moving up and to the right on the four cell matrix) they are able to achieve greater success with health-promoting activity along with a curative agenda. Should regions be restricted

from moving toward being more therapeutic because of a single provincial model of regional form? This question about whether regions should be constrained or be responsive within uniform provincial regionalization models also leads to reflections about structuration theory that were highlighted in the opening chapter of this dissertation and used as a sensitizing concept to guide early development.

Sensitizing concepts provide a lens that benefit researchers in their recognition and identification of themes and process in data (Gilgun, 2014). Elements of structuration theory, particularly considerations about the agency of both local structures and local actors as well as the iterative nature of agency (forming and reforming), have also been identified as sensitizing concepts in this work. This has played out in several ways. First, iterative interactions between regions (as made up of actors) and the province (as policy structure) has surfaced in the characterization of the two phases of regionalization. This refers to the notion that beyond the importance of the legislated mandate or decision space, lies the importance of what a region does with its authority and the question above as to whether all regions should be similarly structured within any one province. Second, it has been pointed out that understanding the interaction around health-promoting activity between individuals/populations (actors) and the region (structure) has been aided by the precepts of structuration theory. Finally, in its fundamental make-up, the theory of therapeutic regions has a regional agency that iteratively aims to be more strategic and more influential over a full range of health-promoting activity including the social determinants of health. In doing so, it is implicit that a therapeutic region would also shape the role and function of the provincial health bureaucracy.

6.4 Conclusions

Final conclusions drawn from this research relate to practice and policy. The practice of improving the health of the population served requires regions to open pathways and remove longstanding barriers. Specifically place-making must be made core to all community engagement activities, organizational spaces (strategic and operational) are needed to foster health-promoting activity and RHA networking needs to be developed to assure a path to health-promoting activity and healthcare for the population served.

Regardless of their legislated mandate, RHAs need to align their mission, vision and budgeting to reflect what they can accomplish. It is not clear when organizations stress a population health vision, yet they do not have the ability to achieve it in terms of corporate structures, resources, programs or networks. While it is acknowledged that strategies and tactics to achieve improvements in population health emerge and change regularly, a vision or aspirational objective of population health should be clear and consistent.

RHAs should emphasize place-making as core to their community engagement; they should create spaces for health-promoting activity in their organization, even if it is a space to work with and through others; and, they should develop policies that allow for long standing strategic partnerships around health-promoting activity instead of being satisfied with fleeting projects and short-term networks. These praxis considerations would open up pathways and potentially remove longstanding barriers in the maze, allowing for greater opportunities for improving health.

This research can and should influence RHA policy. Policy-makers need to fully consider and seek greater clarity about the role of regions in health-promoting activity. This research indicates that health-promoting activity, innovation and achievement occur when a region has the ability to manage both conventional, curative health care and health-promoting activities. Enhanced attention to health-promoting activity could be accommodated by mechanisms of direct RHA governance and management of the responsibility for significant components of public health (such is the case with NH) or mechanisms created by provincial RHA policies that find new ways to bring health-promoting and curative resource decisions, service co-ordination and system evaluation together in a meaningful way. Not including health-promoting activity sufficiently in RHA decision space means that any meaningful advances in health promotion will only occur by chance or in isolation from the goals and needs of an integrated health system.

The nature and structure of regional health organizations matter. Regions should be considered more than mere entities that cyclically administer changes within the healthcare system with little attention to a holistic health-promoting policy agenda. This research explores a new way to conceptualize and consider health regions. The theory developed in this dissertation ascribes health-promoting agency to RHAs. Underlying the theory is the notion that with effective governance and management, a RHA can maximize its legislated scope (decision space) toward being more therapeutic and in this way achieve health promoting activity that meets the needs of the population served by the RHA, which may differ from province-wide health promotion priorities.

A further policy implication of the theory of therapeutic regions is that central health authorities (e.g., provincial governments) can take action to allow local RHAs to

be more effective in advancing both curative and preventative branches of Canadian health policy. The two RHAs explored in in this research, the NWLHIN in Ontario and NH in BC suggest that different approaches to inter-organizational coordination around health-promoting activity yield different potentials for being strategic in the realm of place-making.

Recent work concerning health equity has observed "…administrative structures that separate public health from healthcare can create barriers between health and social services" (PHAC, 2014, p. 26). This is a conclusion of the Public Health Agency of Canada (PHAC) in its analysis of the health sector's contribution to achieving health equity, particularly in relation to the social determinants. In identifying administrative structures as barriers, it alludes to the "incentive structures that may operate against certain kinds of research and intersectoral work" (p.26).

Kirk et al (2014) offer a similar yet specific observation related to the advance of health promotion strategies within BC: "A third possible threat to health promotion is related to organizational changes and continuously shifting priorities at both the health authority and government levels, as well as the synergistic relationship between the two" (p. 20).

Both of these statements intimate at a general level that administrative structures (including RHAs) affect health-promoting activity. The outcome of the research presented here suggests that exploring the three themes in greater depth and across other jurisdictions could guide a fuller understanding of the relationships involved.

Finally, the results of this research have implications for other health-related organizations. Allied health organizations, NGOs, advocacy groups and individuals

should expect a RHA to have agency to act in all three thematic areas identified in this research: place-making, creating space within organizations and networking. Policies and practices within therapeutic regions can be developed to complement and facilitate the evolution of health-promoting activities along the continuums and quadrants identified in the matrix in Figure 6.1.

6.5 Limitations of the Research

It is appropriate to offer observations on the limitations of the research and methodology. At the proposal stage, caution was expressed that the changes in regionalization schemes may undermine the data used in this work. In the early 2000s there had been contractions in the number of health regions in several provinces and the LHINs had been launched in Ontario. It was unclear as to whether those changes signified a trend or were anomalous. However, broadly speaking, while there is always a certain level of change going on, there continues to be general stability in provincial approaches to regionalization. For example, there have been a few changes in provincial regionalization approaches since the beginning of the research and those noted in Chapter 2 fit within an overall pattern of RHA development.

There are, however, a few recent indications that renewed attention to regionalization may soon surface. First, the Auditor General of Canada (2016) reported concerns over the First Nation Health Authority (FNHA) in British Columbia, noting that the FNHA is not a provincial RHA, per se, but a self-governance entity to manage a range of First Nations health programs distributed across the province. This type of focused and yet geographically diffuse RHA may require a model that is different from traditional RHA operations in order to meet and deliver on its mandate. A theory of

therapeutic regions expanded to consider traditional healing could generate helpful discussions in this regard.

Second, the Ontario Minister of Health released a discussion paper on December 17, 2015 that raises questions about the role (scope/decision space) of LHINs. The document also raises specific questions about boundary alignment with other organizations. While the discussion paper focuses on current challenges within Ontario healthcare, writ large, it is clear that a refreshed perspective on regionalization is considered to be an integral part of the government's path towards improvements in the health, not just healthcare of Ontarians.

An unanticipated limitation surfaces with the identification of *place-making* as a central theme arising from key informant interviews with high level managers in the health organizations studied. Pierce et al. (2011) suggest that relational place-making involves understanding the 'place-frames' that emerge from either a contestation or commonality around sense of place. While those key informants opened the door as to allow for identification of the theme, in order to fully explicate *place-making* it would be helpful to broaden the sources of data. Notwithstanding the major role played by senior management in developing health-promoting activity as cited in the literature, the reliance upon the views of senior management may be limiting. While not part of the scope of this initial work, a next step would certainly benefit from investigating the perspectives of place-making held by the individuals served by RHAs.

There is a potential limitation arising from the selection of two rural RHAs with similar attributes in terms of their geographic expanse, nature of settlements and demographics as the study sites. This selection was made purposively to minimize the

effect of certain characteristics on relationships with health-promoting activity and to focus on the differences e.g., governance, organization and the nature of health promoting activity. The question that emerges relates to how rurality may have been a factor shaping the findings. As the coding and analysis advanced and led to the core category of place-making, some messages grounded in the data were clearly related to rural areas. These factors include longstanding considerations with relevance to rural areas in the provision of health care such as: distance, access to service and resources (Kulig & Williams, 2012). Continued reflection on the effect of these dimensions of rurality on Canadian health and place-framing helped reify the place-making theme, yet also raised a question as to whether that theme would be as dominant in other non-rural and non-northern communities. This reflection is not considered in any way to confound the place-making theme, or the relationships among themes or the synthesis displayed in the matrix, rather it prompts additional research questions related to the question of how generalizable the theory of therapeutic regions developed here is to other health regions.

Finally, a limitation is inherent with the experience and perceptions of the researcher. While efforts were taken to ensure the full voice of the interviewees were captured in interviews and to read the documents without bias, only with further investigation of the themes and theory developed in this dissertation will it be clear whether my occupational experience limited the interpretation of the data.

6.6 Future Research

This research is positioned near the forefront of understanding the relationships between RHAs and health-promoting activity. While there is no single standard measure of the definitions and effectiveness of health-promoting activity across all RHAs, this

research has tried to develop a case for improved understanding of what is possible and how RHA policy could advance progress in population health. Based on the findings from this research, health-promoting activity results from more than a RHA's legislated framework (scope). This finding serves to open up other research avenues. The following considerations remain important. Since regions exist at smaller scales than provincial entities, they are better situated and have greater agency to implement health-promoting activities that can address the needs and many of the other social determinants of health of the local population. Accordingly, this theory of the therapeutic region generates several additional research questions.

First, there is a need to more fully understand influence and importance of place-making that would include examining both provider and user perspectives of *place* in health and health-promoting activity. It would be of value to understand how the relationships postulated by the theory of therapeutic landscapes manifest in RHAs that appear to offer differing approaches. For example, how do users perceive place-making across several RHA jurisdictions within BC as compared with jurisdictions within Ontario? Additional qualitative interviews with citizens and local health providers would add different perspectives to the conceptualization of therapeutic regions to help refine the concept of place-making within health service regions, and could also shed further light on ways to develop a more integrated health-promoting healthcare system.

Second, further investigation into place-making and therapeutic regions would help address the question of whether the presence or importance of place-making varies by the geographies of the RHA. Are there differences with place-making within any one province with a common legislated mandate for curative and health-promoting activities?

For example, are there differences in place-making between rural and urban RHAs? If so, do they influence or enhance the basic theory of therapeutic regions?

Third, a consideration of international regionalization experiences would also hold potential value for developing an understanding of the relationships and the theory of therapeutic regions. For example, it is reported that the UK National Health Service (NHS) is embarking upon decentralization of its healthcare budgets and accountability to the City of Manchester in a pilot project that will also allow NHS services to be integrated with a full array of social services that are currently the responsibility of the municipal government (The Economist, 2016).

The integration of a curative and health-promoting policy stream is a key component characteristic of the most therapeutic of regions (the quadrant B in Figure 6.1). Also, how municipal administration may serve as a (devolved) regional health authority to add a new and deeper place-making relationships raises questions. Will integrating the policy streams in the Manchester pilot project provide health system benefits, including better coordinated access to a continuum of preventive care or is system rationalization the underlying and sought after outcome? How does the inclusion of municipal structures into (British Columbia, 1991) (British Columbia, 1993) the RHA modify place-making?

In sum, the question of generalization and further testing of the theory of therapeutic regions are important elements of a future research agenda. Additional research aimed at understanding whether relationships similar to those revealed in this work exist across a wider sample of RHAs would help refine the nature of the two continua (axes) in the representation of the theory (Figure 6.1). It would also aid in

understanding what actions and activities would be involved in improving the position of a RHA on the therapeutic region matrix over time. It is suggested that additional data gathering exercises to further verify the theory and reflect representation of a greater range of Canadian RHAs would be valuable (e.g., urban and suburban), especially if linked with resource allocation or health outcome measures. Understanding how much support (budget and otherwise) goes into various health-promoting activities across RHAs would be valuable to both theory and policy, especially when paired with meaningful and measurable changes in health status.

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Appendix A: Ethics Approvals

University of Victoria | Office of Research Services | Human Research Ethics Board
Administrative Services Building Rm B202 PO Box 1700 STN CSC Victoria BC V8W 2Y2 Canada
T 250-472-4545 | F 250-721-8960 | uvic.ca/research | ethics@uvic.ca

Certificate of Renewed Approval

PRINCIPAL INVESTIGATOR:	**H. James (Jim) Harrold**	**ETHICS PROTOCOL NUMBER** Minimal Risk Review - Delegated	**10-404**
UVic STATUS:	**Ph.D. Student**	ORIGINAL APPROVAL DATE:	01-Nov-10
UVic DEPARTMENT:	**GEOG**	RENEWED ON:	07-Nov-16
SUPERVISOR:	**Dr. Denise Cloutier**	APPROVAL EXPIRY DATE:	31-Oct-17

PROJECT TITLE: **Therapeutic Regions: Relationships between health system regionalization and health promoting activity in Canada**

RESEARCH TEAM MEMBER None

DECLARED PROJECT FUNDING: **None**

CONDITIONS OF APPROVAL

This Certificate of Approval is valid for the above term provided there is no change in the protocol.

Modifications
To make any changes to the approved research procedures in your study, please submit a "Request for Modification" form. You must receive ethics approval before proceeding with your modified protocol.

Renewals
Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol about six weeks before your expiry date.

Project Closures
When you have completed all data collection activities and will have no further contact with participants, please notify the Human Research Ethics Board by submitting a "Notice of Project Completion" form.

Certification

This certifies that the UVic Human Research Ethics Board has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Participants.

[redacted]

Dr. Rachael Scarth
Associate Vice-President Research Operations

Certificate Issued On: 21-Nov-16

10-404 Harrold, H. James (Jim)

northern health

Northern Health Corporate Office
600-299 Victoria Street, Prince George, BC V2L 5B8
Telephone (250) 565-2649, Fax: (250) 565-2640, www.northernhealth.ca

June 28, 2010 File #[redacted]

Jim Harrold
Department of Geography
University of Victoria
PO Box 1700 STN CSC
Victoria BC V8W 2Y2

Dear Jim:

RE: Therapeutic Regions: Relationships between health system regionalization and health promoting activity in Canada

On behalf of the Northern Health Research Review Committee, I would like to thank you for your submission titled "*Therapeutic Regions: Relationships between health system regionalization and health promoting activity in Canada*". The Committee reviewed your application and is willing to grant approval pending receipt of the following information:

1. Please provide a copy of the final version of the consent form
2. Please provide a copy of the R B approval from UV C

Please submit your response to[redacted]

We believe that this is an important project and look forward to receiving your response.

Sincerely,

[redacted]

Dr. Suzanne Johnston, Chair, NH Research Review Committee
Vice President, cademic ffairs and Chief Nursing Officer

SJ sw

CC: Dr. Bowering Dr. Chapman
File

Appendix B: Interview Guide

Interview Guide[13]

Student: Jim Harrold, PhD candidate

Research Title: Therapeutic Regions: Relationships between regional health system regionalization and health promoting activity in Canada.

Research Timeframe: April 2010 to October 2010

Research Participants: RHA/LHIN Key informants

Greeting **(2 mins)**

Introductions.
Thank the participant.
Outline purpose and confidentiality.
Explain the recording device.
Ask for signed consent form, if not previously provided.

Introduction **(8 mins)**

Ask about their personal experience. Current and previous management positions and tenure? What are some of the everyday challenges about planning care in this setting?

Ask about their experience with regional authority implementation. Were they in a similar position when they were introduced?

> *Prompt: probe the number of transitions they have experienced in their career as if they have been here a long time it will be many in BC. Also, how their positions/titles have changed over time would be interesting to explore. Ask about role in implementation.*

Ask about their definition of regionalization and their opinion of general overall purpose of regionalization in the province. What have they read?

[13] Questions will be modified for interviews of allied health and provincial key influencers to reflect their context.

Prompt: about the objectives in this province or others and whether they are aware of any evaluations of health authority regionalization.

Ask about perceptions as to how well objectives are being operationalized and achieved.

Focus on research question 2. (20 mins)

The second question is: how does the implementation of decentralization of health governance/management authority and evolution of local autonomy over local policy direction within a specified regional health authority influence planning and priority setting around health promoting activity for marginalized populations?
Here you will feel you have a good sense of the 'current milieu'
Do you serve marginalized or vulnerable populations? Describe.

What do you know about these populations: how many, locations, need, programs?

How do you know what you know about marginalized or vulnerable populations?

How does working in a regional health authority structure either help/enhance or hinder/impede you providing programs to marginalized or vulnerable populations – in responding please keep in mind the objectives talked about before.

Prompts: Keep on track of discussing both enhancements and impediments.
Can you be specific please about how regionalization helps/hinders? To what extent do you think your observations are shared by others or are yours unique? How do you assess whether the views are shared?

Follow up: How does the province help your programs for marginalized or vulnerable populations? How much flexibility does your RHA have in customizing programs or allocating more funding to health promoting activities or shifting funding within categories? How have cuts influenced service changes? What are the broad trends within health sectors that have influenced care?

Focus on research question 3. (18 mins)

The third set of questions will focus in more detail on the nature of the interactions involved with decisions that are health-promoting activity. The third research question poses: how does agency (the expression of health needs and preferences) of health consumers influence decision-making around health promoting activities for marginalized populations?

How does being closer to the local needs change what you hear from groups advocating on behalf of local health needs of marginalized or vulnerable populations?

Do you closely work with other health promoting organizations in your area? Could you name the top few you interact with regularly and please discuss on what basis these interactions occur?

Is the voice of vulnerable populations heard? How is the voice of health care consumers heard within the regional structure? Do you believe it is listened to carefully? Can you name some examples of successes in this realm?

> *Prompts: Can you recall for me a specific meeting you have had with an allied health organization or a community group around health promoting activities or program investment? (Inquire about public minutes of the meeting)*
>
> *Follow up: How do you think the RHA could work better with allied health organizations or community groups around health promoting activities or programs? What will it take? Are there some short and long-term goals that come to mind?*

Overall **(10 mins)**

Is there anything else you would like to comment on that addresses how you respond to the health and health care needs of populations in your service area?

Are there others in the organization that would have perspectives that would be helpful to this research?

Conclusion **(2 mins)**

Thank the participant.
Reassure as to confidentiality.
Deactivate and securing store recording devices (2).
Reconfirm contact information so they can follow up or ask further questions.