Regional health organisations (RHOs)

Impact, barriers, and facilitators

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Research. Evidence. Action.

Acknowledgements

Quigley J, Coyle C, O’Dwyer C, O’Brien D, O’Nolan G, Farragher L, Long J. (2019) Regional health organisations: An evidence review. Dublin: Health Research Board.

Background

In June **2016** the Irish government established the **Houses of the Oireachtas Committee on the Future of Healthcare** with the goal of achieving cross-party, political agreement on the future direction of the health service

The committee developed and agreed the **Sláintecare Report (2017)** which is a **10-year strategic plan** to transform how healthcare is delivered in Ireland

A core component of this health system reform is the **regionalisation** of the Irish health care system.

Research question(s)

1. What are the documented positive or negative **impacts** or outcomes of adopting a regionalised healthcare system?
2. What are the documented **barriers** to and **facilitators** of effective regionalised healthcare systems?

Properties a regionalised or decentralised healthcare system

1. The first distinction made is between **political and administrative** decentralisation
2. The second property is the **authority** the RHOs have in health
3. A third distinction refers to the **level of government** involved in the transfer of competencies, for example to regional governments or to local authorities
4. **Fiscal** decentralisation is additional concept that can happen alongside political decentralisation

Definitions: Regional health organisations

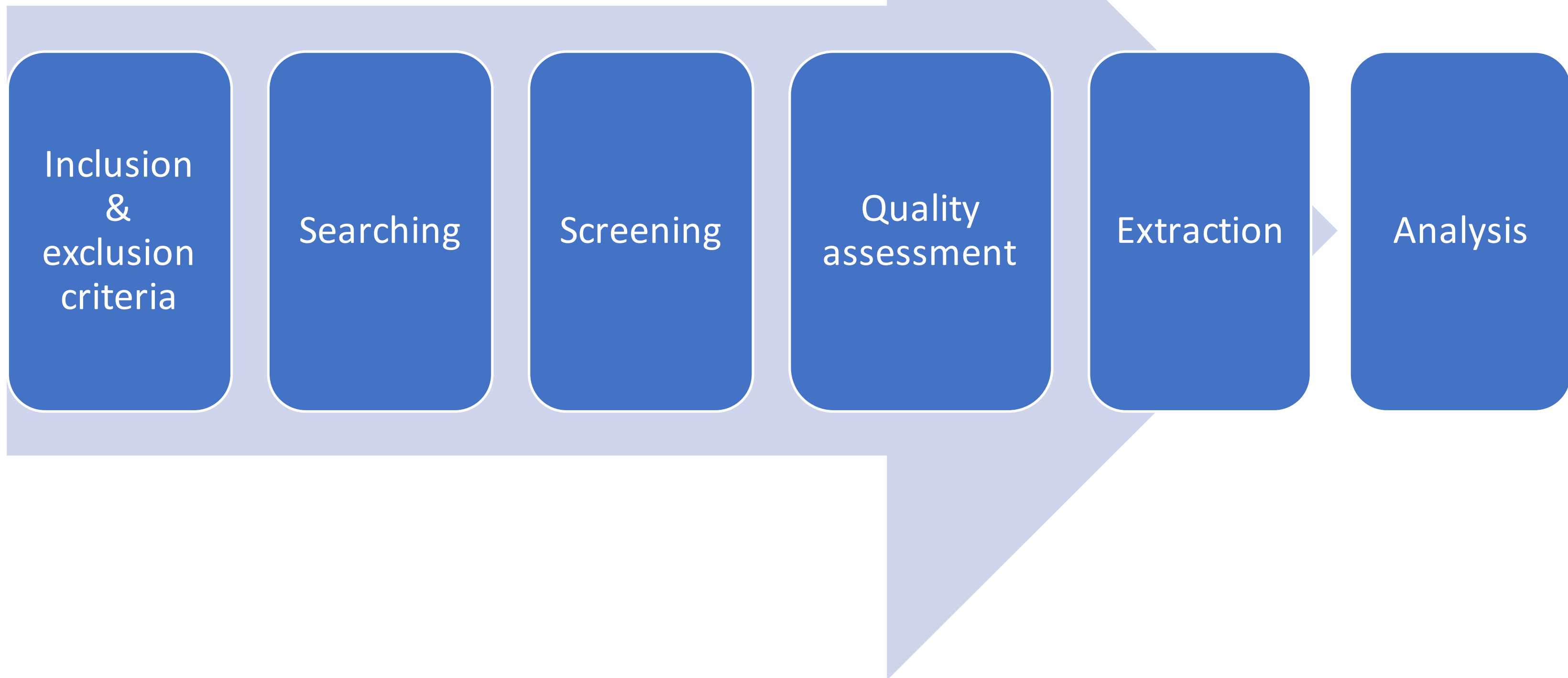
"For the purpose of this review, a RHO refers to an organisation which is responsible for the **provision of acute, primary and social/ community care to a geographically defined population**. The health system in that particular country or province/state must be organised on a regional basis and the regional health organisation must have a **population-based approach to service provision**"

OECD countries that researched impact, barriers, or facilitators

Regionalisation/ administrative decentralisation	Political/fiscal decentralisation
The Canadian provinces	Italy
Greece	Mexico
New Zealand	Spain

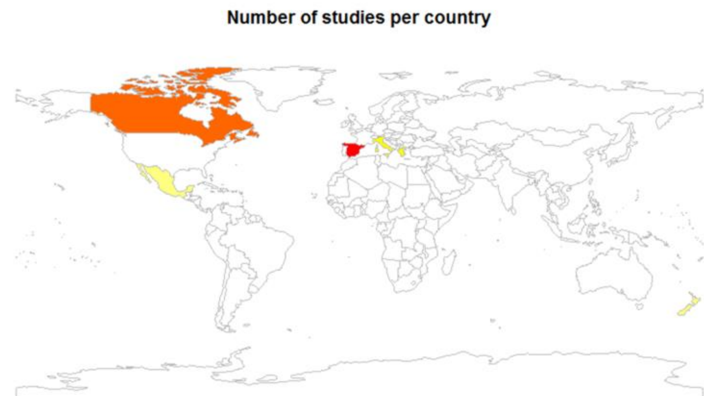
Methods

- Two systematic reviews using **standard methods**:



Impact of RHOs

1. Utilisation of resources
2. Health and care outcomes
3. Efficiency
4. Equity
5. Patient flow
6. Cost

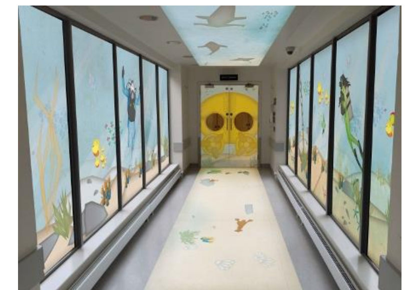


1. Utilisation of resources (13 studies)

- Numbers of hospital separations (or **discharges) fell** in the two years after regionalisation in Canada, which began in the early 1990s (not significant)
- Mean **LOS was shorter** two years after regionalisation (not significant)
- Number of **days of care also fell** in Alberta but not in Newfoundland and Labrador
  - Mainly due to cost containment and budget cuts.

2. Health and care outcomes (12 studies)

- In Canada, regionalisation had **little impact** on healthcare outcomes, but **waiting times increased** in primary (GP) and acute care
- In Spain, **expansion of GP services** was required
- In Spain, decentralisation may have increased crude **mortality** in the first wave of decentralisation and decreased mortality in the second wave. However, most likely influenced by other **contextual factors**
- In Mexico, Italy and Spain, **infant mortality** decreased
  - Limited data on primary, social and community care



3. Efficiency (4 studies)

- Evidence of **increased efficiency** in urban Canada and the management of non-insured persons in Mexico
- **38%** of **total healthcare expenditure** in Canada was allocated to inpatient care after the healthcare reforms were introduced in the early 1990s, and this was likely to have been closer to **50%** prior to healthcare reforms

4. Equity (7 studies)

- In Canada, **inequities increased in rural areas** compared to urban areas
- Equity did **not increase** in **Spain**
- Equity **increased in one region of Italy**, but between region equities decreased

5. Patient flow (4 studies)

- **Travelling for treatment** from less resourced regions to more resourced regions was observed in Canada and Italy

6. Cost (11 studies)

- Generally costs were **not reduced** in Canada**,** Alberta was the only exception
- **Costs per capita increased** in Spain and Mexico
- **Conflicting evidence on expenditures in Italy** post-decentralisation, and this appears to be linked to differences between the north and south of Italy.
  - Majority of costs in healthcare relate to structure, salaries and prescription drugs which are **difficult to decrease** without reducing and reorganising services

Barriers to and facilitators of effective RHOs

Three thematic areas were identified :

1. **Influence of the central government**
2. **Balancing competing interests**
3. **RHO processes and procedures**

Barriers to and facilitators of effective RHOs

1. **Influence of the central government**

Defining RHO size/boundaries

Pace of and resistance to change

Consistency through national strategies

Locally or centrally mandated services

MoH support

Funding allocation and deficit management

Service provision in line with budget

Barriers to and facilitators of effective RHOs

2. Balancing competing interests

Tension between RHOs and MOH

Coordination between RHOs and MOH

Locus of real decision-making

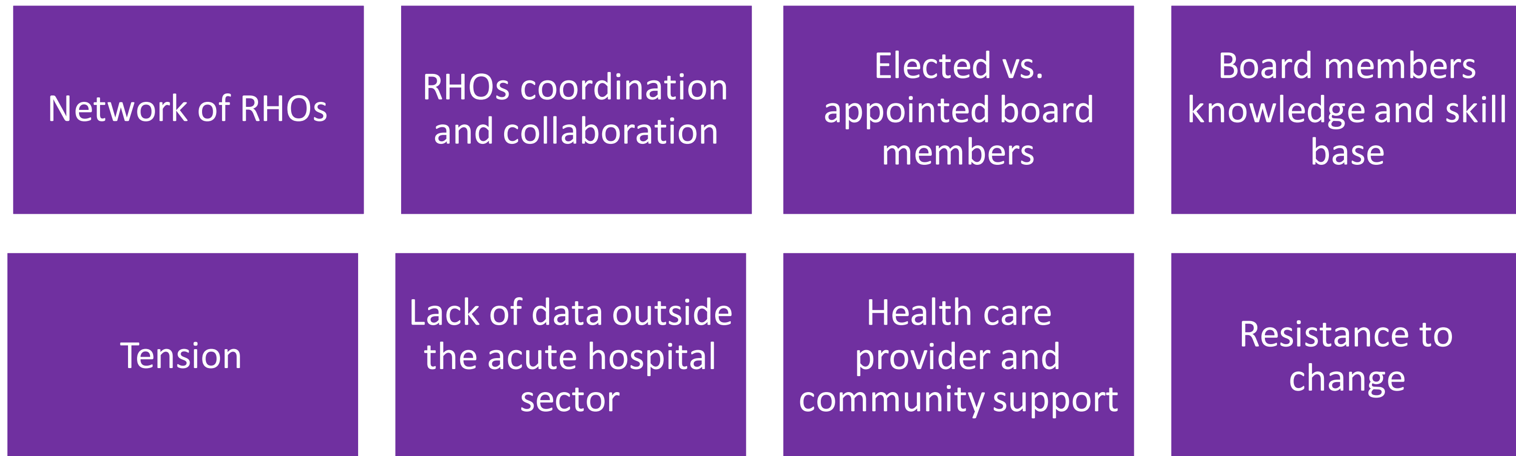
Decision-making and/vs responsibility

Accountability to MOH or population

Resource requirement: needs assessment, planning, reporting

Barriers to and facilitators of effective RHOs

3. RHO processes and procedures



Conclusions and implications

- **Evaluation of RHOs is sparse**
- **No negative impact** observed on long-term care outcomes such as mortality or treatment outcomes
- **Acute care resource utilisation remained similar** post-regionalisation
- **Increase in** resource utilisation in **primary, social and community care**
- **Waiting times** for acute care and primary care **increased**
- First **two to three years** after regionalisation are marked by **instability**

Conclusions and implications

- RHOs cannot address the specific needs of their populations if **funding** is insufficient
- Clarity regarding **roles and responsibilities** as well as **training** is required for RHO boards and the RHO executives
- Community and staff **engagement** are pivotal to ensuring **buy-in** and to facilitating their input into health service design and delivery
- **Outcomes will need to be monitored in all healthcare settings**
- A **high-functioning health information system across the system** will be needed in order to facilitate baseline, monitoring, and evaluation