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Guest editorial

Regionalization and injury prevention and control — a new dynamic or persistent lethargy?

The Canadian government commissioned the National Forum on Health to examine the current health care system, identify which elements need to be preserved through change, and how, through evolution, the system can improve the health of Canadians.[1] The forum, in a report entitled *Canada Health Action; Building on the Legacy*, emphasizes the importance of consumer participation in the next iteration of the Canadian system, a commitment to information systems, and an evidence-based approach in decision making and in the delivery of health care. The report also goes on to identify the importance of early childhood intervention, and investments in programs that preserve and promote child health, including injury prevention.[2] The tenets of this document were largely supported by Canadian Provinical Ministers of Health at a conference on 'A Renewed Vision for Canada's Health System' (May, 1996). Health promotion and protection is expected to be population based and will continue to be delivered largely by public health. The ministers, however, acknowledge that most of these latter programs do not fall under the provisions of the Canada Health Act.

Most provinces have elected to use some form of regionalized delivery of health services to achieve the lofty goals necessary for maintaining and improving Canada's health care system.[3] By moving responsibility for health from provincial control to smaller geographic areas, health care could become more responsive to locally established priorities and foster greater public involvement.[4] Decision making authority would rest with local boards, with the Provincial Ministries of Health relinquishing their service delivery role and focusing almost exclusively on health policy. The British Columbia government merged community services with institutional care on a regional basis and expects this to yield a client centered system that will provide a seamless continuum of health services. The regions will be expected to achieve health goals established by the Minister of Health. The objective will be to maintain traditional health care services and improve the health status of the community.

Do these changes bode well for injury control? The prevention of childhood injuries has been identified as a health objective achievable at a time of health system reform.[5] Moreover, the Provincial Health Officer for British Columbia has identified certain childhood injuries upon which the regions' performances could be evaluated.[6] Some health boards are establishing population health units, calling upon public health practitioners to be responsible for their creation and operation. These units should be able to link community and institutional data bases. Regions could be positioned to more fully measure the scale of childhood injuries and the benefits from their prevention. This approach also could enhance the region's understanding of injuries, educate the public about injury control using local data, and use this information in regional health care planning and resource allocation. In theory, given British Columbia's commitment to injury control,[7] and an effective reorganization, one might anticipate a new era for injury prevention for the province's pediatric population.[8]

What are the barriers to unbridled success? Many of the regions in British Columbia do not have the population base or administrative infrastructure to support regional data collection. Less affluent regions experiencing higher levels of unemployment, factors associated with poorer health generally, may not necessarily prioritize injuries as an area of primary interest. Even if injury control proves attractive, authorities may not be willing or able to divert resources away from high profile, acute care programs to less glamorous programs that have a greater influence on health status — that is, childhood injury control and prevention. In the past, the provincial government has repeatedly earmarked special health funding locked to specific acute programs. The regionalized model also has not allowed health regions to alter physician reimbursement. The community will remain responsible for shouldering prevention costs including injury control efforts. Compounding the situation is the inter-Ministerial reorganization that has moved funding for 80% of public health nursing into a new Ministry for Children and Family. This split of nursing time and accountability has significantly complicated public health program planning and has the potential of diverting public health nursing away from traditional prevention programs to more highly visible child protection and neglect issues. While the shift from unintentional to intentional injuries may be expedient, this could further cripple injury control efforts. Not all regions are using their health officers in population health programs, and this expertise may be lost. As well, the fund raising foundations of the regions' institutions may be reluctant to embrace community programs over equipment purchases.

Other concerns arising from this restructuring relate to the potential expansion of the hospital into the community — the proverbial 'hospital without walls'. A primary concern is that the provision of acute care services in the community may prove to be more expensive than institutionally based services, and thus drain community resources. As well, the indirect costs associated with such shifts could have a considerable bearing on injury prevention efforts. For example, the community has a finite ability to respond to requests on its time. Consequently, appeals for community involvement and participation in childhood injury prevention programs may be supplanted by home based initiatives to care for populations with immediate needs that were previously serviced by institutions.

The future of childhood injury control never looked brighter, nor did the possibility of its marginalization in regionalization appear more imminent.

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