Comparative Provincial Health Reform
Regionalization in Saskatchewan

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Over the past decade and a half, most provinces in Canada have undertaken a

replacing over 400 institutional governing boards across the province. This reorganization was undertaken with the express intent of integrating and rationalizing the delivery of health services in an effort to move the system‟s focus to one where the delivery of primary health care (much of it delivered outside of traditional health care institutions) was at the core of the system. With the changes has come a new driving philosophy for health care; that of health promotion and disease prevention, or "wellness."

After winning a significant majority on October 21, 1999, the NDP set out on a path of full-scale restructuring of the health system driven by a vision that included an emphasis on health promotion and disease prevention. But immediately upon taking power the new government was faced with a budget deficit of $1.7 billion and a net debt of $9.6 billion, amounting to 44 per cent of provincial GDP, growing to 49 per cent in 1993. Resulting from these fiscal circumstances international bond rating companies lower Saskatchewan‟s bond rating greatly increase debt service costs, placing the province on the verge of bankruptcy. The discussions of health care reform were therefore conducted within context of the fiscal situation and implemented in conjunction with fiscal constraint.

The reorganization in Saskatchewan was to be twofold: first a reorganization of the system into Health Districts and then a restructuring of the focus of the system to primary care. The rationale for this two stage approach was relatively simple. Working on the belief that the existing governance structures were in fact a barrier to primary care reform and the better integration of services, the government believed that it needed first

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of local Aboriginal governments (in the form of Tribal Councils) and had significant federal involvement because of that government‟s constitutional responsibility for services to on-reserve Aboriginal

to “wipe the slate clean” so to speak by removing those elements of the system that they felt would be resistance to change. Individual hospital boards (and those of other institutions) could be expected to resist changes that could fundamentally alter their mandates, affect their budgets or even their existence. By eliminating these boards and replacing them with district boards with clear mandates to integrate and coordinate services across a broader geographic region it was felt that the government would then be able to move forward on implementing a more fundamental reorientation of the system.

But, as will become apparent, the second half of the plan – the wide-scale implementation of new primary health care models and the heightened emphasis on prevention and health promotion never really got off the ground. There are numerous reasons for this. First, the public resistance to (or at least resentment of) the institutional changes was strong and forced the government to spend significant time and energy defending the removal of the local institutional governance structures. Second, the financial situation of the province in this time period was particularly precarious and the government‟s attention was diverted towards the elimination of budget deficits and repayment of the accumulated provincial debt. Third, a series of decisions – some related to the restructuring of the health system and some related to the financial crisis in the province – created a widespread public perception that the government‟s commitment to “wellness” was, in fact, a code for government cutbacks and retrenchment of services.

The province‟s financial situation at the beginning of the NDP mandate was so terrible that the Department of Finance called for large-scale budget cuts from many departments. Such cuts forced changes in Health such as a significant raise in the deductible for the provincial drug plan and the conversion of 52 hospitals into

"community health centers." Many people saw these conversions as the *closure* of their

jurisdiction to another, it was extremely difficult. So what was needed was to collapse all of the boards into one integrated governance body that would have a stake in all elements of the system".[3] Each individual section of the health care system had its own board: "Every hospital had their own board; every long-term care facility district had their own board. And so in some cases there were sort of…isolated pockets of where they had worked reasonably well together but (that was not) the norm and certainly that wasn‟t the general appreciation of what was going on. And it was seen as a system that was, particularly in the light of the financial pressures, very dysfunctional and that it didn‟t work well".[4] This caused a fragmentation within the system where facilities that were geographically close to one another were generally not working together or sharing resources.[5]

Having this multitude of boards working within their own stovepipes created a duplication of many services.[6] Many participants in this study pointed to coordination of services as a driving factor for health reform. For example: "we had a lot of independent little fiefdoms…where there wasn‟t a lot of co-operation even between facilities in the same town or city and they didn‟t work together to look at it from a client perspective, how do we provide the best, or at least the perception was that they didn‟t look at it from a client perspective and try and move then through various pieces of the spectrum…in any kind of co-ordinated fashion."[7] Integration and coordination of services in the health system was therefore m r ‘ from a clihe fore ŋ s @ > s

concept of a single board is that it “supports the principles of increased community involvement and the integration and coordination of services in each district”.[8]

In 1990, the Commission on Future Directions in Health Care, known as the Murray Commission, proposed a structural change for the health system to deal with this fragmentation. The Commission was created by the government of Grant Devine at a time when health care costs had reached thirty per cent of government program expenditures. As a result cuts in programs were already being instituted; the Children"s Dental Program was eliminated and cuts were made to the Saskatchewan Drug Plan. The Murray Commission was tasked with examining how health care was organized, delivered and to make reform recommendations. Most of the participants in this study recognized the importance

major structural change in a health care system. Like Louise Simard went to just about every community in the province marketing the move of the district construct."[10] Interviewees consistently named three people who were key drivers in the process: Louise Simard (the Minister of Health), Duane Adams (the DM) and Lorraine Hill (the ADM). These three people worked in concert and drove the entire process. They were responsible for "making sure timelines were met, and agendas were met, and policy was being developed".[11] This situation illustrates is the way the symbiotic relationship between the elected and bureaucratic levels of government that is necessary more often than not for the successful implementation of major policy changes such as the proposed reforms to the healthcare system. This relationship represents a commonality of ideas between the elected and bureaucracy surrounding the necessity and the type of reforms required for the health care system.

The essential difference between the Murray regionalization and the NDP

stress and illness, with supports from family, the community and the health service sector, is part of the wellness approach."[12]

In addition, there was an attempt to filter money out of hospitals and into more primary care settings to de-emphasize acute care. "We knew all the money was in the institutional sector and if we intended to get any help whatever, any money whatever to begin to start a new wellness program we had to get it out of the institutional sector. At that point without knowing we had such a crisis in finance we knew we didn‟t have…new money. So I mean it was an easy guess to say well we‟re going to have to take control of the health sector."[13]

This approach was first articulated in the Murray Commission report, but was emphasized more heavily by the NDP administration: "Simard had tracked the Murray Commission across the province for two years and was very sensitive to the preventative health concept that…of the Murray Commission, things about keeping healthy and the role of the public health, public health professionals as opposed to hospital professionals in that field and the changing roles of workers, hospital workers".[14]

Along with the articulation of wellness goals there was a series of documents to inform the public about the government‟s plan and a large-scale information campaign.[15] The documents outlined the government‟s plan for health reform – which included regionalization among other reforms. Included in the documents published between 1992 and 1994, were: *A Saskatchewan Vision for Health: a Framework for Change, A Guide to Core Service for Saskatchewan Health Districts* and a *Planning Guide for Saskatchewan*

[12] Saskatchewan Health 1993, p.3
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Health Districts (Parts I and II). These documents were the result of a task force on wellness, something that participants affectionately referred to a "skunk works." "We set up this task force on wellness which we put off into the, we called it the skunk works. You probably didn"t know that word. The skunk works, that"s what Louise called it. And the people we put into the skunk works were taking it out of the normal business of government and putting it, we borrowed space at the rehab center I think and put these people in there to give us some of the up-to-date thinking from around the world in what wellness and health should look like…And we have them I think about ninety days to frame this thing 0302Cmal business of

> and social centres," co-operative health centres," „community clinics" or „wellness centres."
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> Ensure that all health services within the district meet specific provincial guidelines and standards.
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> Be governed by a single health board.[17]

The health boards would be composed of locally elected and appointed members, two-thirds of the board would be elected. The belief was that the health boards would reflect local control and responsibility, which in turn would allow for the tailoring of services to meet their specific regional needs.

The information campaign, including all of the public documents and public meetings, was described by an elected official as "a whole cadre of people who actually went out and sold it to the public…this was done to get communities to understand what was behind health reform".[18] "There was a whole crew at the Ministry of Health that pushed the agenda and sold it out on the hustings. And they need to be recognized in any sort of history that"s done because there were public servants out there taking flak…a lot of very diffi00300dd4(nd)-9(a)4(a)4(nd so)-10(ld i)-3(t out)-305A5004B0052004F00480003>7004640f76.2

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Generalizing from participant responses of those who were a part of the civil service at this time, government wanted the public to understand the reasons behind healt

the nurses, and we met with the doctors, and we met with the hospitals, and we met with the nursing homes. And they, you know, we know that they were never all going to agree on some of the things but at least they couldn‟t say we didn‟t talk to them”.[24] The real support from the front lines came from the health leadership. Because of their position of being able to see the larger picture enabled the health leadership to recognize the need for

get them going and they were still opposed to the regionalization and were trying to fight

district model was a radical departure from that."[28] "We needed to make sure that the issue of ownership was not an issue. And it turns out only a very small number of very bright municipalities and municipal councilors understood that the wisest thing they

that because of that it was their hospitals, like you know they owned it, they"d raised the money. Well I mean the fact that all the operating costs for every many years had been paid through tax dollars, had got forgotten. But, so there was that kind of parochial myth to it a bit. And that part wasn" ,'its' Î t ^ r ^ b ' w̄ T 0 y"te ɲ l

achieve. No one was opposed to the vision and ideas surrounding health reform, but the concrete implications were what made various groups flinch. It is very difficult to argue with an idea that proposes better health for the provincial population. However, opposition to health reform arose when announcements were made that there would be conversions of fifty-two small hospitals into community health centers around the province. While government tried to rationalize the decision by explaining these hospitals were lacking the core competencies to deal with many emergent situations, it was too late.[33] Health reform and hospital "closures" had already been rolled into one entity in the public mind: the original plan was considered very progressive "and it"s when the hospital closure announcements were made that things turned because communities rose up against it, the press taking the community stand. And in a way making that announcement on hospital closures and the policy to move forward was very

given the pride that communities have in their institutions, this would not have been a simple task.

Analysis

I mean that always helps is when you"ve got that…when you"ve got at the cabinet table a person who is committed to and understands it well and can sell it".[39] Another participant described the role of the senior civil service: "It was intense and it was Duane (Adams) who drove the timing. He had the view that there was the appetite now for change and if we waited any longer people would start to] n ^ d] ȳ oÆr £ nd c

aspects of health reform were affected by the fiscal crisis; the introduction of the primary care initiative – was never realized largely due to the fiscal situation of the province.[42]

The concept of regionalization was never about cuts to the health care system; at its inception, regionalization was about a way to make the system more sustainable and improve the delivery of services. The reality was such that it ended up getting entangled with an economic policy requiring funding cuts for the stake of the province"s fiscal survival. As such regionalization is still an ongoing process, the structural reforms have been instituted and primary care initiative is still undergoing implementation.

Conclusion

Ideas were key drivers in this: ideas about further integration and coordination of services. The idea, or the vision, was enough to put the restructuring into motion and allowed the key individuals involved to keep pushing reform. There was little opposition to reform at the outset given that leadership in the health field was behind the concept of reform. The community involvement aided in getting interests on-side. No interests would argue against letting communities choose their own regions and elect the majority of their own boards. The creation of the health districts enabled regions to better coordinate the delivery of service through the integration of regional health resources. External events were really the key hampering device that led to the halting of reform before the full concept was carried out. The provincial deficit was such that cuts needed to be made in all areas, not the least of which came from the health care budget. It was after the realization of such a severe deficit and debt that the government decided that they had to convert 52 small hospitals into community health care centres. Because this act followed so closely on the heels of the restructuring, health reform and hospital

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closures became synonymous. This brought forth opposition from many fronts; politically as well as from interest groups, that saw these conversions from the point of view of job loss and more generally, the loss of economic development in many of these small communities. Due to the strong opposition at this point, health care reform initiatives were halted and the second round, which would have included primary care reforms, was never able to be carried out. Almost a decade later the introduction of the *Action Plan for Saskatchewan Health* in 2002 made primary care a health care priority. This was made possible due to the greatly improved fiscal circumstances of the province resulting from the resurgence of the resource sector and the affect it had on government revenue.