After Medicare: Regionalization and Canadian Health Care Reform

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Abstract. In the immediate postwar era the primary object of health reform among the advanced industrial democracies was to expand, if not universalize, access to a broad spectrum of health services through sustained, high levels of government-mandated spending. The fiscal crises of the 1970s and 1980s ushered in a new generation of policies devoted to balancing the imperatives of guaranteeing access to basic health and social services and to improving the accountability, efficiency, and effectiveness of health care industries. In Canada, the regionalization of health care administration emerged as the most prominent strategy for grappling with the contradictions and paradoxes of contemporary health reform. This essay traces the historical evolution of federal-provincial deliberations that elevated regionalization to the forefront of health policy-making in the new era of fiscal restraint, and further, assesses recent efforts to institutionalize regional health authorities.

Keywords. Medicare, regionalization, health reform

Résumé. Parmi les avancées de la démocratie dans le secteur de l’industrie, le premier objectif de la réforme de santé suite à l’après-guerre, a été d’élargir sinon d’universaliser l’accès à un large éventail de services de santé et d’en faire la priorité du gouvernement. Ce dernier également responsable de son financement. La crise économique des années 1970 et 1980 a inauguré la mise en place de nouvelles politiques garantissant l’accès à des services sociaux et de soins de santé de base, ainsi que l’amélioration de la responsabilisation, de l’efficacité et de l’efficience des soins de santé en milieu industriel. Au Canada, la régionalisation de l’administration des soins de santé apparaît comme étant la stratégie la plus empreinte des contradictions et des paradoxes de la réforme en santé de cette époque. Cette étude trace l’évolution historique des délibérations provinciales et fédérales qui ont conduit à l’institutionnalisation, dans le contexte des restrictions fiscales, de la régionalisation des soins de santé.
INTRODUCTION

Canadian health policy witnessed three overlapping transitions in the postwar era. The first, roughly spanning from the close of World War II to 1971, was marked by the steady expansion of federal grants-in-aid for provincially administered health services and successive political victories for universal hospital and medical insurance in both provincial and federal parliaments. National health insurance brought in its wake a second transformation, beginning in the early 1960s and continuing through the 1970s. This was the dramatic growth and reconstruction of ancillary health services: community health clinics, mental health services, nursing homes, home care, public health and prevention services, special-purpose public housing, etc. The third, ongoing transition in Canadian health policy began in the mid-1970s. The release of the Lalonde Report and the advent of the Established Programs Financing Act represented its points of departure. Therapeutic scepticism, a diminished faith in the contributions of acute care to health and well-being, and the restoration of provincial flexibility in health care financing and administration are the hallmarks of this third transitional period.

The reconfiguration of ideas, institutions, and interests embedded in Canadian health policy has provided a permissive context for the resurgence and reinvention of localized health administration in the last four decades. Every provincial government has made important strides in establishing regional, or district, health authorities with broad jurisdiction over the delivery of health services. Regionalization does not represent a commitment to local self-governance as the ultimate end of health policy. Even so, precepts of community involvement, consumer participation and the like have anticipated, and to a certain extent, provided a rationale for, increasing reliance on local authorities for administering health care. Nor has regionalization greatly diminished the importance attached to acute-care services in provincial health budgets, although it has striven for a more equitable balance of investments in health and social services and improved co-ordination between these two branches of health promotion. Regionalization has thus far brought practical definition to a more limited agenda—establishing new forms of accountability and efficiency in the financing and provision of health care—the logic of which has surfaced from the realities of strained public finances, dire predictions of burgeoning demands for acute-care services, and of the perceived lessons drawn from federal and provincial experience with underwriting health services.
This essay develops in three parts. The first considers the changing institutional environment of Canadian health policy since the mid-1970s. By institutional environment, I am specifically referring to the ideological, fiscal, and technological forces that have set the national context for health policy deliberations. These elements underwent important transformations in the era of Medicare. Rapid development of communication and transportation technologies in the broadest sense, and technological advances more specific to health care, have vastly expanded the ways in which health services may be monitored, supervised, organized, and delivered. Ideologically and fiscally, the dynamics of federal-provincial relations have reaffirmed the basic tenets of federal intervention into health care financing: universality, comprehensiveness, accessibility, and public administration. But Canadian governments have also acknowledged accountability, efficiency, and effectiveness as cardinal virtues governing health policy-making. These novel rationales for justifying policy, added to the original guiding principles of Medicare, have created new opportunities for innovation in health care financing and organization.

Part 2 describes the regional organization of health services in Canada from the mid-1960s to the 1980s. The purpose here is twofold. The first is to provide historical and analytical benchmarks for contrasting newer and older approaches to health services districting, with particular attention to incipient models of regionalization in Quebec and Saskatchewan. Earlier regional health authorities operated primarily within the confines of the allied health services sector and tended toward fragmentation and poor co-ordination. Current attempts at regionalization represent a concerted attempt to overcome the characteristically centrifugal drift of the old, while advancing social services models of health care financing and delivery. The second motive for surveying the historical development of regional health care administration is to trace the origins of provincial endorsements of regionalization as a medium of health reform. Understanding how provincial governments came to embrace regionalization as a vehicle for making the health care system more accountable, affordable, and effective begs consideration of the lessons that the provinces have drawn from their historical experience with health services districting.

Part 3 provides an overview of the defining moments and features of policy making in the 1990s. The discussion here illustrates how the architecture of health care districting has balanced the complex objectives of health reform. Correspondingly, I take up some of the paradoxes embodied in the health regions model. To date, administrative rationalization has taken precedence as the object of reform across the nation: the creation of district health boards charged with co-ordinating the work of several branches of the health care establishment—hospitals, nursing homes, clinics, home care agencies, and other sundry health agencies...
operating within their boundaries. The democratic pretexts of health districting emphasizing localized, participatory governance of health regions have given way to technocratic standards of accountability in the transition to health services integration—deference to the expertise of provincial ministries in setting the agenda for local reform. Implementing the wellness paradigm that emerged from the decades-long conversation between federal and provincial governments over the priorities of health services has proven to be the slow boring of hard boards, but appears to have reaffirmed the historical importance of adequate primary care in Canada. Ultimately, regionalization appears to have taken its place in the historical evolution of Medicare as an enduring, yet ambiguous and contested institution—as with Medicare itself—and one that will channel health reform in Canada for the foreseeable future.

THE EVOLVING NATIONAL CONTEXT

The context of Canadian health policy underwent a transformation in the 1970s and 1980s in two overlapping, complementary streams. The first movement, beginning in the 1970s, represented a departure from the consensus that had underpinned national health insurance in at least two respects, one ideological, and the other, fiscal. Ideologically, federal and provincial governments began to rethink the contributions of acute-care services to health and well-being. Fiscally, the original cost-sharing formula joining together federal and provincial spending on health insurance fell prey to extensive criticism, and eventual dissolution. The second movement came in the 1980s. It coincided with the growth of health services research in Canada, associated technological advances in health care delivery, and progress in the statistical and evaluative sciences. The appearance of cadres of university-based health services researchers in the social and medical sciences brought greater clarity and definition to critiques of medical organizations and practices. These same experts often generated dismal scenarios of the impact of aging cohorts on an unreconstructed health care system. Criticism of the acute-care sector also arrived in tandem with the increasing sophistication of community-based and outpatient health services. The joining of these two streams created a window of opportunity for reinventing the administration of Canadian health services.

HEALTH CARE IN QUESTION

The early 1970s witnessed national health insurance’s ultimate assimilation into Canadian political life, and paradoxically, the incipient transformation of its ideological and fiscal underpinnings. The beginnings of a decisive shift in Canadian thinking about the relative contributions
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of medical and hospital care to health came with the release of the Lalonde Report, *A New Perspective on the Health of Canadians*. Marc Lalonde stressed the importance of environmental factors and life-style choices on health as opposed to acute-care services. The report was the first of several to question implicitly or explicitly the preference given to medical and hospital care in provincial health budgets. The report owed some of its influence to gathering scepticism of medical care growing out the accumulation of cross-national data on health care spending and health indicators. It was easier to call into doubt the value of acute-care services with demonstratively weak evidence of a correlation between longevity, disability, and infant mortality on the one hand, and acute-care spending on the other, among the advanced industrial democracies.

It was also easier to condemn the flaws of Canadian health policy than to specify in convincing detail what sort of arrangements should take their place. Lalonde raised questions, but fell short of outlining a comprehensive set of practical adjustments to federal and provincial policy that would establish a proper balance between preventative, environmental, and acute-care branches of health promotion. One obstacle to achieving such a balance lay in the provisions of federal hospital and medical insurance acts. The 50-50 cost-sharing formula of federal grants-in-aid for universal health insurance sought to reconcile two conflicting objectives. The first was giving the provinces the strongest possible incentive to enact public health insurance: raise provincial taxes to meet federal requirements or have provincial residents pay federal taxes to support universal programs in other provinces. The second aim was to have the provinces internalize enough of the costs of universal insurance to become responsible purchasers of health care. To the extent that federal funding succeeded in the first instance, it weakened provincial discretion in substituting other health services for hospital and medical care.

The *Established Programs Financing Act* of 1977 represented an important milestone along the road leading to more provincial flexibility and a new generation of health policy. The familiar pattern of Canadian federalism following in the wake of Established Programs Financing—the yielding of more tax points to the provinces, recourse to less restrictive federal block grants to the provinces, and equalization guarantees culminating in the Canada Health and Social Transfer—gave the provinces more discretion in allocating funds among the various branches of the health care establishment. This broad retreat from federal oversight of provincial health and welfare services had key exceptions of course, namely, federal specifications for universality, comprehensiveness, portability, and public administration for hospital and medical insurance. The *Canada Health Act* of 1984 reaffirmed these principles contrary to the general trend in intergovernmental relations favouring more provincial
autonomy. But to enforce these principles the federal government resorted to withholds rather than shoring up fiscal inducements as it had in the past. The emphasis on sticks over carrots was embodied in federal penalties assessed against user fees and balance billing. Thus, Canadian health care policy remained wedded to the original intent of federal grants-in-aid of hospital and medical insurance, but has allowed the provinces to satisfy those criteria within a wider scope of fiscal effort: spend down, spend up, or spend differently. Reducing or reallocating provincial spending would no longer bring automatic reductions in federal spending.

TOWARD A NEW MODEL OF HEALTH CARE: WELLNESS, SOCIAL ENGINEERING, AND LOCALISM

The 1970s had witnessed an ideological shift—from unqualified faith in the value of acute-care services to a rediscovery of prevention and health promotion—and new cost-sharing agreements among the federal and provincial governments. The former offered a rationale for reorienting provincial health policy, and the latter, opportunities to reprioritize health spending. Developments in the 1980s and early 1990s strengthened the reform impulse and saw the rise of public debates that favoured localized administration as a modus operandi for channelling health policy reform. Three emergent movements put Canada on the path to health care reform. The first was the proliferation of health care analysts, social forecasting, and attendant controversies over the likely impact on the demand for health care of a burgeoning elderly population. Second, the technological sophistication of health care grew in Canada and most other OECD countries, as well as the scope and finesse of research on the appropriateness and effectiveness of health services. And third, the federal government moved beyond the vague critique of Canadian health care entailed in the Lalonde Report and endeavoured to sharpen the debate over the future of health policy with the 1986 release of Achieving Health For All. The combined thrusts of these developments crowned social engineering as the leitmotif of health policy-making in Canada and de-emphasized reliance on medical and hospital care in health promotion.

The emergent focus on managing the social determinants of health introduced a new vocabulary for talking about health care in Canada and prioritized in spirit the development of organizations compatible with this new ethos. The Canadian health care system, as constituted in the 1970s and 1980s, took on the pejorative label sickness system in public debates. With lessening frequency the causes of health and well-being were identified with hospital wards and doctors’ offices in Canada. A wellness paradigm that located good health in the attributes of individuals,
families, neighbourhoods, communities, schools, and workplaces rose to the fore. The favoured vehicle for promoting health gravitated toward community-based health services, those services oriented toward promoting healthy lifestyle choices, and calculated adjustments to the immediate social networks in which individuals live out their daily experience. The logic of health care reform increasingly revolved around notions of local-ness in the 1980s.

A perceived crisis in Canadian health policy in the 1980s began with debates over the future of health care for the elderly. The upward shift in life expectancy in the postwar era, the rapid expansion of institutionalized care for the aged in the same period, and the anticipated mushrooming of the elderly population in the opening decades of the 21st century served as one catalyst for widening the debate over the funding and organization of Canadian health care. Providers groups, on the one hand, most notably the Canadian Medical Association, responded to projections for increased demand for health care among the elderly with calls for hikes in public spending or expanding the scale and scope of private funding for health care. Contrarily, health care researchers called into the question the assumption that demographic shifts required further investments in acute care. Further, they shed doubt on the appropriateness of providers’ response to the needs of the elderly. What policymakers need do, so went the critique, is de-institutionalize and de-medicalize health services for the elderly. Provincial governments sided with de-institutionalization. No provinces proposed increasing hospital and nursing home beds or expanding the ranks of practicing physicians as cornerstones of health care policy as they had in the past.

Technological advances in medical care also created a permissive context for building down the acute-care sector. The American experience has been particularly instructive. The advent of certificate-of-need laws governing capital investment in hospitals during the 1970s, and then the introduction of Medicare’s prospective reimbursement schedule for hospital care in the mid-1980s, increased dramatically investment in outpatient facilities in the United States, and correspondingly, reduced significantly the length of hospital stays. The attendant push toward day surgery and supporting advances in less invasive diagnostic and surgical procedures saw hospital bed vacancies rise in the US. Lessons drawn from American hospitalization patterns were not lost on Canadian observers. Diagnostic, surgical, and convalescent services have correspondingly been re-designated and reorganized as outpatient services in Canada. Other technical advances, in particular, the refinement and expansion of the evaluative sciences, have weighed in on the side of those who envisage pruning acute-care services without observable harm. The rapid growth of health services research among public and then private insurers in the US, combined with public funding for out-
comes research and formulating clinical practice guidelines, surpassed anything of its kind in Canada in the 1980s and 1990s. The outcomes movement had nevertheless established several beachheads in Canada in the 1980s. The preliminary findings and conclusions of outcomes research in both Canada and the US have generally supported allegations of excessive medical treatment and hospitalization. Health services research has served as a critical legitimating device to build down the acute-care sector through claims to expert knowledge developed independently of health care professionals and organizations.

A third, major contributing force to the de-medicalization movement came with the 1986 release of Achieving Health for All. The federal report sought to recreate the symbolic terrain of health care politicking in Canada. Rather than mount a comprehensive critique of the acute-care sector, Achieving Health consciously made little mention of medical and hospital care. It was an attempt to establish a forward-looking blueprint for provincial health policy, however little fiscal power the federal government had at its disposal to impose new norms on the provinces. Nevertheless, the report did much to redefine the problem of health in a way that marginalized acute care, and the document became a touchstone for provincial deliberations following in its wake. Achieving Health defined health in social and psychological terms and extolled the virtues of health promotion and prevention. As distinct from medical engineering with its attendant focus on coping with ill health, the report looked to social engineering as a new model for health promotion in Canada. It suggested that the imperatives of public policy should be the creation of a social order conducive to good health. It thus introduced a new criterion into policy making: all policies should be assessed in terms of their contributions to health. To imply, as Achieving Health did, that transforming people’s health requires transforming society, raises the difficult issue of the appropriate scope of public policy—to be discussed later in this essay. More relevant to the purposes at hand, the report made a distinction between health promotion mechanisms and implementation strategies that gave added credence to health services reorganization on a local level.

Achieving Health identified self-help and mutual aid as two of three key mediums of health promotion. The former concerned individual lifestyle choices, and the latter, everyday social networks. Self help would require that Canadians’ beliefs, values, and behaviours assimilate what is known about the influence of personal habits on good and ill health, ostensibly through better health education in every conceivable setting, such as homes, schools, workplaces, and recreational sites. Mutual aid made more explicit reference to social support networks described as critical to preserving and promoting personal well-being, including families, neighbourhoods, voluntary associations and self-help groups. To
develop the full potential of these health promotion mechanisms, *Achieving Health* exhorted direct, public participation in health services planning at the community level to give institutional expression to this new paradigm. It further named community health services as the appropriate conduit, providing as it were “a natural focal point for co-ordinating services such as assessment, home care, counselling and the valuable work of volunteers,” along with the entire spectrum of social services. Local accountability and co-ordination had moved to the centre stage in Canadian health care debates.

To reiterate, the ideological, fiscal and technological foundations of Canadian health policy underwent considerable change since the introduction of national health insurance. In broad outline, the Canadian experience mirrors those of other affluent democracies where the costs and efficacy of health care came under intense scrutiny. However much retrenchment has provided the overarching theme for policy development in Canada and abroad, policy responses have varied greatly. In the US and the UK, for example, establishing new forms of market competition in health care became the chosen medium for promoting patient control over health care and for improving the efficiency of health services. In Canada, policy debates have likewise favoured decentralization of health care governance, more individual participation in securing health and health care and better value for money. These same arguments have not located sovereignty in markets, but re-affirmed democratic control of health services. Canadian reforms have preferred *voice* to *exit* to appropriate Albert Hirschman’s classical distinction.

This notion of local control over health resources had several reinforcing logics in Canada. The health promotion paradigm so described above contributed one argument. The growing documentation of unnecessary and ineffective care in the acute-care sector contributed yet another. The perceived need to rein in health care spending in general and the associated desire to promote less invasive and less intensive care for the elderly as a substitute for comparatively expensive, institutional health services also buttressed calls for elevating locally organized, community health services to the forefront of health policy. And more broadly, the growing recognition of the need to provide a well-integrated continuum of care so as to smoothly move all patients, not just the elderly, out of acute-care settings to less costly community-based settings gave added force to the notion of localizing health services co-ordination.

THE EVOLVING PROVINCIAL CONTEXT

Provincial governments have long resorted to varied forms of regional governance, administration, and provision in health care. National
debates over health reform that promoted regionalization drew inspiration from, and accelerated, provincial initiatives to expand and reconstruct health and social services in the 1960s, 1970s and 1980s—policies that had greatly extended the reach and importance of district-level health care administration. Though regionalization has appeared in many guises, and broad generalizations about regional health organizations would invite lengthy qualifications, a much simplified description would yield the following properties: provincially funded and organized; appointed as opposed to elected governing boards; and functional segmentation within and among various branches of the health services. By the 1980s, the provinces were collectively primed for a thorough re-examination of the successes and failures of regionalized health services, and as such, they became a receptive audience for national proposals that envisaged comprehensive, yet localized, solutions to the problems of health care financing and organization.

Unlike the United States, where county governments have often served as basic units of administration, funding, and provision of publicly sponsored health services, provincial governments have generally looked upon local governments as unequal to the task of organizing health services on a district or precinct basis. The provinces have commonly withheld from municipal governments intermediate roles in organizing and governing health services, with the exception of public health measures. In their place came provincially appointed boards largely drawing from local, interested parties, either as purveyors or consumers of districted services. Or, in the case of hospitals and the various special care homes, the governing boards of these institutions were thought to serve equivalent representative and administrative functions. In developing provincially funded health services, the provinces have normally introduced special-purpose health districts that crisscrossed or amalgamated the boundaries of several local governments. The regional boards also tended to pillarize health delivery since stepwise regionalization had been the prevalent form of health services districting. That is, the provinces tended to regionalize health services in a sequential manner along functional lines including mental health services, home care, nursing home care, and community health services.

The following discussion briefly recounts the evolution of health districting in the provinces of Quebec and Saskatchewan to illustrate previous manifestations of regional health care administration. The principal critiques of health districts as constituted in the 1960s and 1970s concerned their failure to establish a continuum of care either by way of securing mutual accommodations among providers or through unified administration and budgeting. Further, local accountability was rarely obtained; vertical linkages to provincial health departments and horizontal linkages among providers were the rule. Health districts exhibited
a common pattern of fiscal dependence on the provincial ministry, nominal supervision, and little formal accountability to local constituencies. Notwithstanding these perceived shortcomings, the experience of older regional bodies provided the basis for a new synthesis of concepts and practices that would augur well for the reconstruction of health districts.

QUEBEC

Quebec made the first attempt in the national health insurance era to implement comprehensive, district-level health administration in Canada. The Quebec experiment with district health councils represented a comparatively advanced effort to rationalize health care delivery at the local level, relative to the more ad hoc development of primary, secondary, and tertiary health services in the other provinces. The concept of regional health administration in Quebec made its debut in the Castonguay-Nepveu Commission reports in the late 1960s and early 1970s. The Commission recommended the creation of regional health authorities with a mandate to: (1) integrate primary, secondary, and tertiary health services into a single, unified administrative framework so as to better ensure continuity of care in the province; and (2) give institutional expression to a new model of health care, that of social medicine, which gave equal recognition to the social, environmental, and biological determinants of health. The practice of social medicine detailed in Castonguay-Nepveu envisaged inter-disciplinary health teams comprising physicians, social workers, and allied therapists who focused on prevention so as to make recourse to specialized hospital and medical services one of last resort.

The implementation of health services districting in Quebec strayed from the ideals of Castonguay-Nepveu. The provincial government’s desire to pacify physicians and hospitals made health care reform in Quebec assume the more familiar pattern of policy-making incrementalism as opposed to the thorough-going reconstruction called for in Castonguay-Nepveu. The desire to elevate social medicine and preventive services found comparatively mild expression in the creation of local community service centers (CLSCs) and departments of community health (DSCs). CLSCs and DSCs were grafted onto the acute-care sector and became new segments of an otherwise fragmented health care system. CLSCs embodied the principles of social medicine, but fell short of recruiting a majority of physicians into this avant-garde of medical practice. They did, however, contribute to the spread of private polyclinics, or group medical practices. While the DSCs uprooted public health services and located them near, or inside hospitals, there is little to suggest they were successful in injecting a prevention ethos into the strongholds of
highly specialized, secondary and tertiary health care. Notwithstanding these efforts, it was, rather, in the realm of decentralization where the major thrusts of Castonguay-Nepveu witnessed more impressive gains.

The creation of regional social service and health councils (CRSSSs) in the early 1970s and their subsequent development placed Quebec in front of the other provinces on the road to regionalizing health care administration. The regional councils held modest responsibilities upon their inception: to advise the ministry on administrative, financing, and planning issues while providing a venue for consultation and collaboration among local health service agencies. By the early 1980s, the councils had in stages gathered unto themselves significant administrative powers. CRSSSs first assumed control over planning, budgeting, and evaluating the allied health services—mental health, home care, ambulance, and other community-based services—powers later extended to review and approve the programs and financing of health care establishments such as hospitals and nursing homes. The various administrative commissions operating under the auspices of the CRSSSs developed programs for joint-purchasing supplies for health care agencies, extensive plans for resource-sharing trained on curbing excess duplication of technology, equipment, and personnel, and made strides in coordinating once disparate services so as to provide effective continuity of care.14 By the 1980s, Quebec’s regional councils constituted the most advanced experiment in district-level health administration in Canada.

SASKATCHEWAN: REGIONALIZATION LOST AND FOUND

Saskatchewan health districts came full circle in the postwar era—from the birth of the health regions concept, to its abandonment, and eventual resurrection. When Tommy Douglas came to power at the beginning of the CCF’s nearly 20-year reign in the province, his newly minted Health Services Survey Commission envisaged the creation of a health care system comprising 14 health regions. Each district would operate a comprehensive health service for local residents under one co-ordinate authority. These regional health governments were to offer a full spectrum of preventative and curative services with community health centers (salaried group medical practices) as the cornerstone of the new model health care.15 The only surviving remnant of the first ever attempt at comprehensive health planning in the province was Swift Current Health Region No. 1, one of two pilot regions created in the 1940s, and later dismantled in the 1960s with the introduction of provincial medical insurance. Organized medicine’s opposition to expanding salaried group practice and local resistance to reorganization vitiated the health regions model. The emerging ethos governing health services delivery uniquely attributed to the province the required expertise and capital to plan health care financing and delivery.
Sequential, as opposed to comprehensive, regionalization became the predominant form of provincial health initiative in the 1960s and 1970s in the drive to reconstruct and expanded the allied health services. Mental health services were first to come under the rubric of provincially funded and organized districts in the mid-1960s. Saskatchewan spearheaded the movement to de-institutionalize the mentally ill in Canada with the planned development of mental health districts (MHDs). MHDs built and administered regional clinics and developed other community-based services to reduce admissions to provincial asylums. Following them came regional Ambulance Boards, and most notably, Home Care Boards (HCBs) in the 1970s. The HCBs greatly expanded the scale and scope of domiciliary health and social services. The re-appearance of health services districting contributed to an emerging patchwork quilt of health programs operating under the auspices of the provincial ministry. The launching of these programs represented the attainment of a laudable objective: the creation of a complete spectrum of health services, at adequate levels, throughout the province.

Incremental extensions to provincial funding of these diverse services had nonetheless culminated in a growing frustration with provincial administration. Both the costs of health care and poor co-ordination among the various branches of the health care establishment had inserted themselves into the centre of health policy debates by the early 1980s. As for costs, provincial formulas for arriving at annual estimates for health care spending rewarded increased use by using past utilization as base lines. Prospective budgets were not tempered with any transparent criteria governing appropriate utilization. Thus hospitals, special care homes, and home care all witnessed hikes in utilization when, in theory, the addition of provincial supports for home care should have lightened the case loads of hospitals and nursing homes. Base-line budgeting gave rise to another hallmark of health services provision in the province: inconsistent patterns of use from locality to locality. Such variance suggested that utilization rates did not reflect accurately underlying needs for services, but were the artifacts of the idiosyncratic preferences of local health care professionals and institutions.

Co-ordination problems were as serious as mounting costs. The provincial health department had become balkanized from within along functional lines: medical, hospital, nursing home, mental health, public health, and home care services. Each service had its division within the department with little evidence of communication among them. Even in the presence of an expressed desire for co-operation among the diverse branches, the administrative barriers to co-ordination were formidable. The units of administration in each case were incompatible. Regional boards did not have common geographical boundaries for each dis-
stricted service whereas the institution served as the unit for administra-
tion for hospital and special home care, and in the case of medical care, individual physicians. The lack of any shared geographical referents among health care providers, regionalized health services boards, and local governments, made for administrative complexity, and ultimately, poor co-ordination.

Demands for improved co-ordination appeared with the provincially backed expansion of the long-term care sector. Long-term care and community-based services had developed on an ad hoc basis with partial provincial subsidies, and then in the late 1970s and early 1980s, the province expanded funding to broaden access and establish a more even, adequate distribution of services. Soon after, the ministry and the health care associations began to exhort local providers to create regional co-ordinating committees to better integrate acute, institutional, and community-based services given the obstacles to effective co-ordination within the ministry. From the early 1980s onward, hospitals, special care homes, home care boards, and public housing authorities in the localities responded by establishing assessment and placement agencies (APAs). These were public, non-profit agencies, jointly funded by area health care providers. APAs employed social workers and nurses who performed field assessments of prospective beneficiaries of any long-term care or community-based service and then passed on recommendations for appropriate care to respective applicants and providers. APA recommendations were not necessarily binding on either party, but the agencies nonetheless made great strides toward creating an integrated continuum of care by providing a clearinghouse for information for both. A process for assessing and prioritizing client needs and matching them with available services had come together for the first time.

By the mid-1980s, a consensus had emerged within the ministry and the Saskatchewan Health-Care Association (SHCA), the umbrella organization representing providers of most institutional and community-based services that the future of health care administration rested on decentralizing co-ordination and supervision of health services. The ministry and the SHCA had drawn inspiration from the well-received implementation of the APAs in the localities and from the associated successes of case management for allocating long-term care. The perceived need to provide a seamless continuum of appropriate care had elevated the concept of regionalized co-ordination to the forefront of public deliberation over the direction of Saskatchewan health care. The SHCA exhorted the province to establish a more formal and permanent framework for co-ordinating and integrating health services on a regional level that stood to benefit from the goodwill and experience of the local APAs.
The provincial response was to commission a study to provide the province with options for reinventing health care administration on a district or regional basis. So named for its principal architect, R. G. Murray, the Murray report strayed beyond the comparatively modest scope of inquiry attributed to it by its sponsors. The SHCA and the provincial government were initially concerned with bringing the long-term care sector out of disarray. It was here that the potential benefits of regional co-ordination and integration were most apparent. Neither party contemplated a wholesale re-prioritizing of health care financing and organization. The timing of the Murray report would disappoint these expectations.

The release of *Achieving Health for All* prefaced Murray, and an unanticipated synergy emerged between provincial demands for comparatively mild administrative reform and the federal government’s more sweeping proposals for a new health services paradigm that favored local, civic participation in health care decision making. The Murray report became a lodestone, attracting as it did, and incorporating, many distinct strands of reform that demonstrated some degree of consistency. Murray was no longer confining itself to the matter of administrative rationalization and regionalization. Health districting had become a chosen instrument for realizing broader ambitions: the promise of bringing health services under local, democratic control; giving institutional expression to a wellness paradigm; and providing an organizational vehicle for improving the knowledge base surrounding the appropriateness and effectiveness of health services.\(^{17}\)

*Future Directions* laid a good deal of the foundation for deliberations over contemporary reform in Saskatchewan. Since it subscribed to the guiding principles of *Achieving Health for All, Future Directions* created one of those rare moments of federal-provincial agreement in a policy domain otherwise riven with discord. *Achieving Health and Future Directions* went much farther in each other’s company than either could have alone. Relative to the cacophony over federal cost-sharing, these two reports suggested a prevailing consensus in inter-governmental forums on the future of health reform in Canada. *Future Directions* and like-minded commission reports that surfaced in most of the other provinces in the late 1980s and early 1990s marked the point of departure for a new stage of deliberation and institution building across the nation.\(^{18}\)

**ACCOUNTABILITY, EFFICIENCY, AND EFFECTIVENESS**

As the evolution of health care districting in Saskatchewan and Quebec shows, regionalization in both provinces was first identified with provision: establishing an adequate minimum of services throughout the province. It increasingly became a vehicle for health care adminis-
tration and co-ordination, whether through voluntary efforts as demonstrated in Saskatchewan or through the more elaborate, formal mechanisms in Quebec. In the late 1980s and early 1990s, a third generation of health policies bent on refining and extending the role of regional health administration seemed imminent. The newer versions of regionalization would advance the efforts of previous ones, namely, to improve continuity of care and to better co-ordinate a broad range of health and social services. Apart from realizing greater efficiencies in health care by accelerating administrative reforms, regionalization held out the promise of a new era of accountability. It could serve as an instrument for civic participation in health policy making and for enlarging the capacities of provincial governments to monitor health services and set health care priorities. The overall effectiveness of the Canadian health care system would also stand to benefit from new approaches to regionalization, serving as conduits for health promotion as presaged in Achieving Health for All.

In the last two decades, the immediate task of institution building has not assigned equal weight and importance to all these laudable objectives. No one of these goals necessarily implies the others, however much Achieving Health and Future Directions were inclined to see elective affinities between them and advertise them as a coherent, integrated set of reforms. In providing regional health districts with stable points of reference for their continued operation, the provinces necessarily gave priority to administrative reorganization and provincial accountability. The rationale underlying the sequencing of district reforms was relatively transparent. Administrative reform was the key to all others. Only when the districts had assumed greater responsibilities for managing and budgeting health services within their jurisdictions, would they acquire the means to accomplish other reform objectives. District accountability to the provinces would have no basis but in a working machinery of financial accounting and administrative hierarchy for monitoring health services in the localities. To give practical definition to a wellness paradigm would require broad authority to allocate resources among district health services so as to channel resources from acute to preventative care. Elevating democratization over and above administrative rationalization might compromise provincial accountability and the objectives of the wellness paradigm. The health districts, if primarily brought under local and democratic control, would not inevitably converge on the model envisaged by the provinces. Administrative reorganization, provincial accountability, and a wellness approach were to be the starting points of local deliberations, not the uncertain outcome of district-level politics.
ACCOUNTABILITY

Incipient debates over regionalization embodied unresolved tensions between two competing norms of accountability. The democratic version attributed surpassing importance to registering, and acting upon, locally derived preferences. The administrative version privileged district responsibility for collecting and transmitting information to provincial ministries of health, specific and accurate enough to allow these departments to modify province-wide policies, plans, and budgets. How these disparate models of accountability would limit the scope of one another was unclear at the outset of reform. In Quebec, for example, it appeared that the civic model might assume great importance. With the 1989 release of *Improving Health and Well-Being in Quebec*, the stage was set for re-evaluating the accomplishments of the regional social service and health councils. The ministry’s white paper upheld the basic tenets and strategic recommendations of *Achieving Health*, in particular, the importance assigned to citizen involvement in setting health care priorities.

In this new light, the representative functions of existing regional social service and health councils (CRSSSs) were found wanting. In the province’s estimation the local constituencies that the councils had come to represent were providers, not patients. CRSSSs had leaned heavily on the expertise and representation of health professionals and institutions in all phases and aspects of their deliberations and administration. All professions and organizations selectively collect, manage, and publicize information to buffer them from environmental threats to their autonomy, survival, and growth. Whether this is done consciously or is the collateral product of other, implicit motivations and behaviours matters less. Health care providers in Quebec did not likely constitute the exception that proves the rule, or, at least the provincial government assumed as much. In sum, the province concluded that the councils had become captive to health care providers.

The lesson of Quebec’s experiment with regionalization was that providers could dominate local agenda setting in the absence of any countervailing power, if administrative co-ordination of health services became the primary object of regional governance. Such countervailing power might appear in two guises, one democratic, and the other, technocratic. The civic route to balancing the influence of health care providers would have regional boards brought under popular control. Across the nation, provincial governments have considered institutionalizing new forms of civic participation, born of optimism about the willingness and capacity of citizens to grasp the objectives of reform and to propel them forward. But what starts out as a strategy for mobilizing consent can also end up enabling resistance. Democratization can
slow reforms by institutionalizing the right to oppose them, or by bringing out groups with an axe to grind. As such, the provinces have commonly opted not to ground reform in the shifting sands of localized health politics. The representative functions of regional health boards have alternatively been deferred, scaled back, or modified, and the civic thrust of health reform has given way to concepts of transparency—the right of Canadians to be informed of the workings and performance of their health care system. The technocratic route to countervailing power would require regional boards to acquire information and intelligence about the appropriateness and effectiveness of health care independently of the claims and information originating with providers. In Quebec, the CRSSSs had not given much effort to cultivating alternative approaches to gathering and evaluating data about health services under their supervision. Operating without basic tools of assessment—extensive investments in epidemiological knowledge chief among them—the councils had primarily depended on the kinds of information and knowledge that health care agencies were willing to make available. Concerted efforts to overcome this knowledge deficit were perhaps destined to displace localized, civic images of accountability with provincialized, administrative ones. District accountability to the provinces, namely, the creation of standardized systems for collecting and reporting data to the ministries for the purposes of evaluating the performance of the health districts, of determining regional budgets, and of modifying health policies and planning, has become the more compelling object of health reform. Regional health districts have nevertheless generated new avenues for representation and deliberation, even if the long-term implications of these intermediaries for health care governance in Canada remain an open question. Given the high profile of health issues in federal and provincial elections, it seems unlikely that Canadians will come to view district assemblies and forums as the primary vehicle for registering their preferences on health policy in the public realm. Though not subject to thorough democratic control, district health boards have institutionalized and bolstered lay participation in local health care governance. Provincial appointments to district boards have created opportunities for enlarging representation from marginalized populations with distinctive health concerns and needs that are generally overlooked in broader deliberations over health policy. Lay participation in district affairs has also balanced to some extent the influence of provincial ministries of health and local health care providers, even though it introduces added complexity and turbulence into regional governance.
Regionalization has long been understood as a promising instrument for improving the appropriateness of health care in Canada. The search for greater efficiency has historically placed a heavy premium on administrative reorganization, namely, the formation of unified, localized supervision over diverse branches of the health care establishment, excepting physician services. Decentralization held out the prospect of yielding immediate dividends from realizing unexploited economies of scope and scale in health care administration: ensuring better continuity of care as well as more easily bridging the formidable divides between intensive, costly services and more extensive, but less expensive, ones. Apart from the short-term benefits of health services integration, the long-term dividends would be drawn from shifting the overall balance of resources devoted to curative and preventative services, institutional and community-based care, and health and social services. As such, regionalization carried new methodologies for the budgeting health care. It provided a window of opportunity for introducing forms of prospective budgeting that peg allocations to estimates of underlying needs for health services, rather than taking existing service patterns as baselines for future appropriations. Calibrating funding to the demographic profiles of health districts spurred the elaboration of increasingly sophisticated measures and models for determining the appropriate use of health services, subject to ongoing revisions consistent with advances in health services research. Canadian governments, as with others, are banking on expert knowledge to better guide public spending on health and social services in the quest for more profound and lasting efficiencies in health care delivery.

Saskatchewan became an early exemplar of these new approaches to promoting efficiencies in the health care system. There, reforms began with the passing of the Health Districts Act and the formal establishment of regional health districts in 1993. The following year the province disbanded the governing boards of publicly owned health corporations in the province—hospital and nursing home boards, the home care boards, the mental health boards, the ambulance boards, the public health departments of local government—and regrouped them under the direct supervision of the district boards. The province also empowered regional authorities to negotiate the service contracts of non-profit and for-profit agencies operating within existing networks of publicly funded health and social services. Correspondingly, the province reorganized the health department to complement district responsibilities. With the immediate charge of administering and overseeing health services passing to the districts, the ministry reassigned the majority of its administrative staff to the regional authorities. This leaner department
redirected its efforts to providing strategic programmatic and planning guidance, developing and disseminating technical expertise on information management, and budget review.

Growing out the movement toward information-based management came accountability increasingly rooted in the application of expert knowledge, epidemiology and demography in the early stages of reform, for determining health care needs and budgets. The province historically allocated monies to health care providers on the basis of past utilization with all the attendant disadvantages noted earlier. With the establishment of the districts, the province no longer distributed funds directly to specific facilities, agencies, or programs, and further, the districts cannot resort to aggregating budget requests from supervised health agencies and then pass along these estimates for provincial approval. Rather, the province has mandated population-based funding for the regions. This is a variation of prospective budgeting based on elaborate formulas that control for population size, adjusted for age, sex, and other indicators of health status and needs.

The fiscal leverage of the province remains undiminished with the introduction of population-based funding. Health district authorities have no powers to tax. The province raises the needed revenues and determines the global budgets for each health district, a process that largely absents health care providers from direct deliberations over allocations. Provincial budgeting methodologies require district authorities to conduct a yearly census and continuing needs surveys and assessments. The districts have been designated as data-gatherers for the province. The incipient logic of health services budgeting under regionalization has been to convert, to the greatest extent possible, programmatic issues into technical ones through appeals to bodies of knowledge embedded in fields of health services research—epidemiology, biostatistics, econometrics, and so on.

While population-based budgeting has accompanied significant improvements in the health services infrastructure in Canada, it has been subject to powerful cross-currents that have blunted the thrust of reform. The temptation to relieve tensions over health reform and to defer painful or politically hazardous transitions by infusing more money into the system has proven difficult to resist. The return of a robust economy and expanding government revenues in the late 1990s and early 2000s, lingering public suspicion of regionalization as a cost-cutting expedient, and popular demands for prioritizing government spending on surgical and diagnostic services to shorten waiting lists for acute care have variously diluted the impact of new methodologies for budgeting health services, notwithstanding government pronouncements reaffirming the importance of a wellness approach to health reform.
EFFECTIVENESS

Provincial reforms thus far have sought to recreate governance: formal decision-making processes, budgeting, and administrative supervision. Changes devoted to improving the overall effectiveness of the health care system have risen to the fore. Implementing a wellness approach to health promotion, a long-envisaged objective of health reform, is nevertheless a laborious task. Moving too quickly to de-institutionalize health services and give priority to community-based care can generate unwanted dislocations and discontinuities of care in the near term. Incrementalism has prevailed in the transition period. The wellness paradigm—with its emphasis on primary health services, social medicine, public education, and building social support networks—bespeaks lengthy, time-consuming investments in both institution building and what is now commonly referred to as social capital. It is both a social and socializing process, and a comparatively slow one relative to administrative reform.

The prospects for institutionalizing the wellness paradigm also seem less certain than other reforms. It is doubtful how far the provinces can travel in the direction of social medicine with reforms exempting traditional fee-for-service medical practice. The provinces have generally temporized on medical reform to avoid confrontations with doctors that threatened to stall progress on regionalization. Many provinces have experimented with plans for reconstructing medical practice along the lines of Quebec’s local community service centres: capitated or salaried medical practices integrated into multidisciplinary health teams. But provincial planning thus far has emphasized relatively modest steps in this direction, suggesting a transitional period of many years, beginning after the consolidation of current reforms and assuming the wellness paradigm will not have lost any of its ideological force or institutional momentum. Whether social medicine will simply become a competing alternative to conventional fee-for-service medicine or the dominant pattern of medical practice through provincial determination is yet to be seen. Thus far, progress on shifting resources from illness to wellness services appears modest. Moreover, to invest total faith in the wellness paradigm may eventually lead to hopes betrayed. The optimism of the national health insurance movement—attributing to the acute-care system the power to eradicate disease and disability—may have lost much of its lustre in Canada. Does the same fate await the preventionist cause? Or is there a compromise on the horizon that gives balanced recognition to both? Part of the answer lies in whether provincial leadership can determine with greater precision, the contributions of the acute-care system to health and well-being, and further, grapple intelligently with the paradoxes and limits of health promotion.
It is true that medical engineering has yet to devise ways of fundamentally altering the course of most degenerative, chronic diseases or afflictions that proximately account for most deaths. To judge the performance of acute-care services solely on the basis of mortality and morbidity rates may not bring us closer to understanding the value of medical and hospital care. If the consensus has it that social and environmental conditions largely determine life expectancy and health status, then it does not follow that the performance of acute-care services can be evaluated according to these indicators. They say little about the contributions of health care to quality of life, the extent to which acute-care services relieve pain and suffering and keep people active. Knowledge of this kind is in short supply. No country has so far demonstrated revolutionary advances in closing this information gap, though increasingly, health services researchers are turning their attention to these kinds of questions. Absent more definitive answers, arriving at practical decisions about the appropriate balance between preventative services and those acute-care services devoted to rendering the lives of the sick more tolerable may come very slowly.

The health promotion paradigm itself has to face difficult questions about the appropriateness and effectiveness of managing the social determinants of health. Health promotion campaigns of the past lead to immediate, visible health gains. The public health movement of the late 19th century, trained on purifying water supply, regulating sewage, enforcing safe building codes, and subsequently, vaccinations and immunizations, etc., posted measurable improvements in the general health of the population. Present-day extensions of health promotion, on the other hand, project themselves into the realm of the social—as opposed to the environmental—that directly touches upon things personal and private. Further, they often call for immediate sacrifices in the short run in exchange for more diffuse and less visible benefits in the distant future. Many of these efforts must go forward without the assistance of settled controversies about which changes to individual and social behaviours yield the greatest improvements in health status. And even in those instances of consensus over behaviours that promote good health, the social sciences cannot offer conclusive evidence about how to best go about inducing them. There is the ever-present possibility that the social engineering approach to health will collapse under the weight of unrealistic expectations, as did the medical engineering model of yesteryear.

An important assumption of the wellness paradigm is that an equal distribution of health should be the aim of health policy. Since formalizing universal access to medical and hospital care under Medicare did not equalize the health status of Canadians, the health promotion paradigm suggests that extra efforts must be made outside the boundaries of the acute-care system to right the balance. Thus, as long as health inequali-
ties persist, it could be said that a proactive wellness paradigm will maintain its raison d’être. Historical experience does not generally support the notion that health promotion can narrow these differences, however noble the aim. For example, public education campaigns designed to combat smoking, drug abuse, and poor eating habits suggest that the educated and wealthy more commonly internalize these messages and make the appropriate life-style changes. Health promotion runs the risk of reaffirming long-standing inequalities of health status. 33

CONCLUSION

The concept of regional governance has evolved in tandem with the changing institutional environments of Canadian policy making over the past half-century, beginning with concerns for adequate provision of health services and ending with the movement for accountability, affordability, and effectiveness. The primary achievements of recent efforts to reconstruct health services districting have been administrative and technical (top-down), and it remains to be seen whether the democratic and social aims of reform (bottom-up) will assume a greater importance in the long run. Health district planning has largely been carried out in terms of imposing provincially determined norms and standards upon the regional authorities. The guiding rationality has been found in technique—devising formulas, standards, and priorities derived from a growing corpus of findings in health services research. Nevertheless, district policy will also be made through a process of institutionalizing dialogue between the provinces, health district boards, and local constituencies rather than through the application of technique. 34 The future of health policy will also revolve around reaching accommodations among the competing values that inhere in social and medical models of health promotion. The outlines of the new synthesis are not entirely apparent, but the long-term success of health districts will rest on defining health problems realistically in terms of the capacity of the acute-care system and community-based services to address them. Notwithstanding these enduring dilemmas of health reform in Canada, regionalization has become a major catalyst for addressing present needs to improve the performance of the health care system, while reaffirming Medicare’s historic commitments to universal access to adequate health services.
NOTES

5 The stripping away of the hospitals’ previous monopoly over sophisticated health care technologies in the US has not been replicated in toto in Canada. While there is a well-defined movement in Canada to locate after care of hospital-based procedures to the home and intermediate care agencies, the technological preeminence of Canadian hospitals goes largely unchallenged. The provinces have typically placed rigorous controls on capital investments in freestanding clinics and practices bent on duplicating the technological prowess of the hospitals. Provincial payments under the medical care acts similarly discourage physicians from performing procedural as opposed to cognitive services. Canadian hospitals carry on as repositories of high technology, but these same technologies have already diminished greatly the custodial role of Canadian hospitals. Every province posted reductions in public hospital beds in the 1980s and 1990s. Canadians have done with fewer hospitals and hospital beds, but the surviving hospitals remain vital institutions.
7 Canada, HWC, Achieving Health For All: A Framework for Health Promotion (Ottawa: HWC, 1986).
8 Canada, Achieving Health For All, p. 10.
15 Saskatchewan, Health Services Survey Commission (HSSC), Report (Regina: HSSC, 1944); Saskatchewan, HSSC, Report (Regina: HSSC, 1945); see also Gordon Lawson’s contribution to this volume.
17 Saskatchewan, Commission on Directions in Health Care, Future Directions for Health Care in Saskatchewan (Regina: The Commission, 1990).
19 Quebec, MSSS, Improving Health and Well-Being in Quebec.
20 Quebec, MSSS, A Reform Centered on the Citizen.
25 Saskatchewan, Statutes, The Health Districts Act (Regina, 1993).


34 Contandriopoulos et al., “Governance Structures and Political Processes in a Public System.”