

Regionalization – Newfoundland and Labrador

Health care reform and restructuring in Newfoundland and Labrador has been driven largely by regionalization of service delivery and management. In the early 1990s, Newfoundland and Labrador, along with many other provinces across the country (with the exception of Ontario), identified the concept of regionalization as a way to cope with spiralling health care expenditures. The purpose of this paper is twofold. First we will review the conditions under which regionalization evolved in Newfoundland and Labrador, the reasons why decision-makers endorsed the concept, reactions from health care professionals and the general population and what future, if any, the strategy holds for service delivery. Second, we will discuss in some detail how regionalization developed as it did since 1990 through a tripartite framework of the public agenda, the decision-making agenda and policy choice. Did regionalization emerge in response to a fiscal crisis in health care as a way for the government of the day to decentralize responsibility to newly created institutional bodies or were decision-makers attracted to the concept as a vehicle for pluralizing policy making and enabling medical delivery more sensitive to the needs of local communities? Answers to these questions will, I argue, begin a conversation about the utility and direction of regionalization in the province and dissemination of new ideas about making health care sustainable and accessible. We will argue that regionalization was embraced by the provincial government because it did not affect the hegemonic position of physicians in the health system, it did not cost more than the old health system and it could be marketed to citizens as a method of achieving efficiencies and making patient care better.

PART ONE: THE BRAIN COMMISSION AND THE GENESIS OF REGIONALIZATION

The origins of regional health care delivery can be found in *The Royal Commission on Health* report chaired by Lord Brain. The Commission, established by the Smallwood government in 1965, sought to report on all facets of the health system in Newfoundland and Labrador and to make recommendations with respect to improving the system. The Commission was created in an environment where hospital insurance was less than one decade old and publicly funded medicare had not yet been created. As well, the population of the province was increasing and greater demands were being placed on a variety of medical services and institutions responsible for their delivery.

The Commission made the following specific recommendations with respect to the regionalization of health services:

1. that the provincial department of health become the planning body for the entire health system with an increase in staff. The deputy minister would become the province's chief medical officer and be responsible for advising the Minister on medical issues. A senior civil servant (Chief Secretary) would be appointed to be responsible for issues pertaining to implementation and program development.
2. the province establish regional health boards which would be responsible to the Minister of Health for medical services in the regions as well as daily

management of said services.

3. the province establish a Provincial Health Council appointed by the Minister of Health. The Council should include representatives from the medical professions, lay groups and other interested parties and its basic responsibility would be to provide a consultative forum to assist with the Department of Health's planning activities.
4. the province should be divided into regions and each would be the responsibility of a regional health board. Each board would have two senior officers (regional medical officer and a secretary) and sufficient staff. The board would be responsible for directing preventive medicine and community health programs. The boards would be financed by the Ministry of Health and be responsible to the Minister (Commission, 1966:133-135).

The recommendations most significant to the evolution of regional health delivery concern the creation of the Provincial Health Council and the establishment of regional health boards. The Commission recommended the creation of a Provincial Health Council based on the argument that

“[o]ne of the greatest single factors brought out in meeting people involved in the health services of Newfoundland is their lack of knowledge of past or of likely future developments. ... Consultative machinery is, therefore, essential” (Commission, 1966: 74-75).

The Council was intended to be a forum for consultation and advice. The Council was to be composed of representatives from the following bodies:

- § Memorial University
- § Newfoundland Hospital Association
- § Chairs of the Regional Health Boards
- § Newfoundland Psychiatric Association
- § Minister of Health
- § Newfoundland Medical Association
- § Royal College of Physicians and Surgeons (Canada)
- § General Medical Council of Newfoundland.

The Commission recommended that the Provincial Health Council meet quarterly, be able to address issues referred to it by the Minister of Health, have the power to bring issues to the attention of the Minister and be able to create both standing and ad hoc committees to investigate and report on medical matters. The Council would be required to write an annual report to the Minister which would be made public. The Commission hoped that the establishment of the Provincial Health Council would make planning and consultation more efficient and rational.

With respect to the regional health boards, the Commission suggested that the size and number

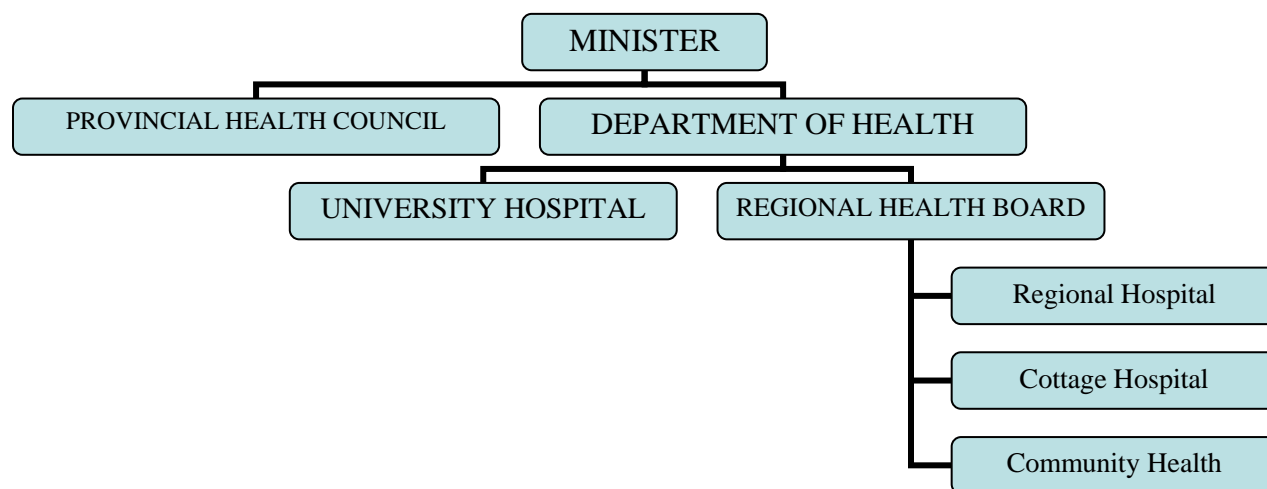
of boards to be created be based on population, available health infrastructure, future health needs of residents and modes of communication available in the next decade. The idea was to create regions with a sufficiently large population that would be able to sustain a regional hospital from which all other services would be located with respect to administration. A board would be appointed that would have responsibility for the day to day management of health services in the region. The Commission suggested that 25 percent of the boards be composed of physicians. All board members would be appointed by the Minister of Health for three year terms with the option of seeking re-appointment. Each board would have a Regional Medical Officer and a Secretary as senior officers. The boards would be financed by the Department of Health and be accountable for their actions to the Minister. In areas where hospitals were not owned by the government (for example in St. John's), the boards would exercise responsibility for their health services by entering into contractual arrangements with these facilities to reimburse them for costs. As well, representatives from non-government hospitals would be invited to sit on the boards in their regions. As the Commission noted, “[w]ith the rapid advances in medicine and the spiralling of the cost of health services, there is no place in the future for the isolated unit providing a small spectrum of services” (85-86).

The proposed health board regions were:

- § St. Anthony, the Northern Peninsula and Labrador;
- § Corner Brook and Southwest Newfoundland;
- § Clarenville or Come-By-Chance and the Burin Peninsula, and
- § St. John's and the Avalon Peninsula.

A model for health care governance based on the recommendations of the Commission is illustrated below.

FIGURE 1: SUGGESTED MODEL FOR HEALTH CARE GOVERNANCE



The *Royal Commission on Health* represented one of the most comprehensive reviews of Newfoundland and Labrador's medical system since the province joined Canada in 1949. While regionalization was not the most important recommendation, the Commission did recognize that health planning and delivery were significant drivers of cost and access for residents. Following the release of the Commission's report, the provincial government adopted the Medical Care Plan (MCP) to provide payment for visits to physicians by residents of the province. By the late 1960s, Newfoundland and Labrador had entered into an era of publicly funded hospital and medical care.

PART TWO: DEFINING REGIONALIZATION AND HEALTH PLANNING IN THE 1970s

During the 1970s, the government of Newfoundland and Labrador began to feel the challenges of governing a province that was, and continues to be, fiscally challenged. Costs for social programs, education and health were increasing and the provincial debt and deficit were soaring out of control. A number of reports were written attempting to deal with these challenges as well as improving the delivery of health care and the health of the province's residents. Two significant reports were issued early in the decade: The Newfoundland and Labrador Health Council's report on regionalization of health services and the Health Study Group's overview of health care delivery. Both reports supported the regionalization of health services in the province and focussed on issues related to governance.

A Concept of Regionalisation of Health Care Services in the Province of Newfoundland was completed in May, 1972 by the Newfoundland and Labrador Health Council. The Council attempted to research the different models and methods in which regionalized health services could be adopted in the province. The Council also sought to develop a shared definition of what regionalization meant, its goals and the establishment of particular geographic areas for health care management. The Council defined regionalization as "the delegation by the Department of Health (and some other Departments or agencies) of certain administrative powers to bodies set up in various regions of the province" (Council, 1972: 1). More specifically, the Council identified several goals for the development of a regional health system based on reviews of the extant literature. These goals include:

- more opportunities for post-graduate education for health professionals;
- participation in the regional organization and planning of health education to assist in the recruitment of health professionals to different areas of the province;
- advisory bodies for small institutions and agencies that might not be able to hire sufficient specialists;
- the systematic sharing and use of medical equipment and personnel including hospital services, beds, laboratory services, nursing and public health, and purchase of supplies;
- uniform methods of reporting financial and professional activities so that better comparisons and evaluations can be carried out to determine efficiencies;
- development of medical research programs that are geographically specific;
- ability to recommend new forms of health service for specific regions;
- creation of public health programs at the community level, and

- encouraging participation of health care professionals on a regional basis rather than on an institutional basis (Council, 1972: 2-3).

The Council's report covers a number of topics including the issue of boundaries, variations in delivery systems, regional administration and financial responsibility. The Council passed the following recommendations in 1971 and included them in the report:

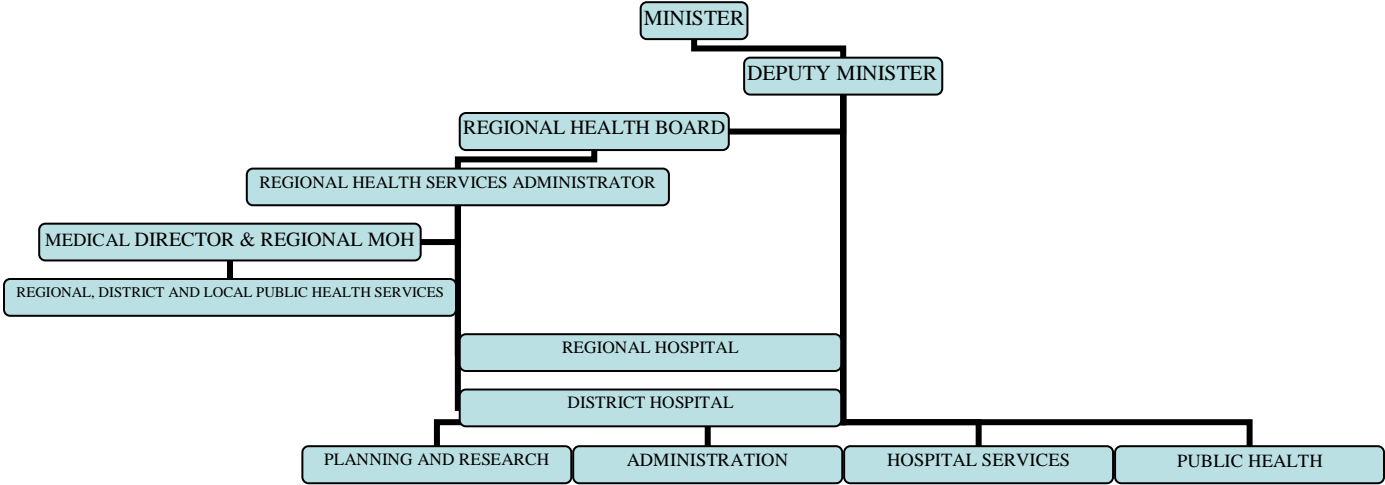
1. the Department of Health adopt regionalization of health as an official policy and delegate responsibility to regional health boards for research and planning; organization and administration and evaluation of health services.
2. the number of health regions to be established number four or five depending upon future trends and developments.
3. all health services funded by the provincial Treasury and the majority of social services be included in the regionalization model and that boards co-ordinate their activities with those of voluntary agencies.
4. the Department of Health adopt the following as primary responsibilities: research, long term planning and evaluation, co-ordination of regional services, liaison with agencies and departments and financial control over health spending.
5. the regional boards should be established in regional centres but not out of regional hospitals or derived from existing hospital boards. Boards should have a membership of between 15 and 20. Members should be both appointed and elected and boards should have representation from health professions. Boards would be accountable to the Minister of Health with permanent staff consisting of administrative, medical and nursing officers.
6. the boards be financed through a block (global) system of budgeting.
7. a general outline for regionalized health services be developed for the whole province.
8. a pilot project with a five year duration be introduced in Central Newfoundland with funding to come from the federal department of National Health and Welfare (Council, 1972: 23-24).

What did the Council envisage as a model of governance for a regionalized health system? Unlike the Brain Commission, the Council thought that boards could either be appointed or mixed appointed and elected. However, the Council's report does not indicate how members would be elected or appointed although it does note that

“[p]olitics do enter into the decisions made for the provision of health care facilities, so why not bring this out into the open? Any disadvantage occurring through politics is balanced by the fact that an elected body is more responsive to the wishes of the people than an appointed body” (15).

The chief executive officers of the board would be a Regional Health Services Administrator and a Medical Director. The Medical Director would be responsible for public health in the region as well as advising the Health Services Administrator on all medical matters. The Administrator of each board would be responsible for co-ordinating services with the administrators of the medical facilities within each region.

FIGURE 2: MODEL OF GOVERNANCE PROPOSED BY THE HEALTH COUNCIL



One final comment concerns funding for the proposed health boards. The Council stressed that the boards were required to have financial responsibility in order for the concept of regionalization to work. As early as 1971-72, it was acknowledged that without financial autonomy, health boards would simply be delivery vehicles for health care: “It cannot be

stressed too strongly that significant financial responsibility for Boards is essential if the regionalisation concept is to be successfully implemented” (20).

Following the study completed by the Newfoundland and Labrador Health Council, the provincial government established a Health Planning and Development Committee in 1972 to assist in the design of a health and social services system that would promote the well being of people across the province. The Committee undertook its task by reviewing the extant literature, undertaking an architectural review of all medical facilities across the province, holding hearings with interested groups and liaising with both Memorial University and the federal government. Out of the Committee came a separate group known as the Health Study Group. This body was composed of provincial representatives from the Health Planning and Development Committee and federal officials acted as a resource and advisory group to supply background information only. The Health Study Group’s report, *Health Care Delivery: An Overview*, published in 1973 is much more of a “made in Newfoundland” approach to health than the work of the Health Planning and Development Committee.

The Health Study Group put forward several suggestions with respect to regionalization of health services and delivery. These include:

1. the definition of regionalization established by the Newfoundland and Labrador Health Council be accepted.
2. a pilot project be implemented in Central Newfoundland to evaluate the results of regionalization based on the Health Council’s definition.
3. during the pilot project, the provincial Department of Health undertake the following functions: (a) research at the provincial level; (b) long-term planning and evaluation; (c) service co-ordination across different health regions; (d) liaison with other government departments and agencies; (e) setting goals and standards; (f) engaging in consultative services; (g) overall financial control and responsibility for setting regional budgets for health services; (h) act as a Court of Appeal where conflicts arise between health boards and service agencies.
4. a Regional Health Board be established with the following functions: (1) engage in detailed local research and planning; (2) organization and administration of services; (3) evaluation of regional services; (4) responsibility for preparing the regional budget for approval by the Department of Health and for the allocation of funds to specific health institutions and practitioners within the region; (5) provision for consultative services (Health Study Group, 1973: xviii-xix).

The desire to focus on regionalization came from the manner in which the health care system was organized. The Group reported that a lack of integration between health and social services was the norm in Newfoundland. With the exception of the Northern Peninsula and Labrador, health and social services were executed separately and without much co-ordination. As the Group noted,

“Regionalisation of administration of health services may be considered one of the options available which should more effectively utilise available [sic] resources. On the basis of its population, Newfoundland, by mainland standards, is not large enough to be considered as more than one region. On the basis of its geography however, regionalisation of health services should be considered as one means of providing a more responsive and effective system (Health Study Group, 1973: 151)”.

Adopting the definition of regionalization put forward by the Newfoundland and Labrador Health Council, the Group argued that the province should be divided into four health regions: Northern (Northern Peninsula and all of Labrador); Central; Western and Eastern. The boundaries for the proposed regions are very similar to those outlined in the Brain Commission report in 1966. The Health Study Group noted four management systems that could be employed for regional health services: (1) management by the provincial civil service; (2) by the government with assistance from a regional advisory board; (3) by a regional executive board with powers derived from hospitals and community health services in the region, and (4) by a regional board with executive and fiscal authority derived from the provincial government (Health Study Group, 1973: 152). The Group stated that boards could be appointed, elected or a mixture of members appointed and elected. The preference expressed in the report was for either a regional board with executive and fiscal power or a board that was a regional sub-division of relevant government departments. A purely advisory board would, according to the report, not be viable because any decisions undertaken would not be binding on those individuals and groups involved in the regions. Making the board a sub-division of a government department is problematic in that it excludes public participation and creates another layer of bureaucracy that might adversely affect innovation. The Group recommended the establishment of regional health boards with full executive and fiscal powers. Board members would be given adequate training and board staff would be professional full-time employees. The exact relationships between the newly created boards and the government would be determined through consultations with all groups involved. In essence, under this model of regionalization, the boards would be located between the hospitals and government and communication between the latter would occur through the health boards (Health Study Group, 1973: 153).

The types of services placed under the regional health boards according to the report should, at minimum, include those procedures provided by the provincial Department of Health and related activities as well as those carried out the Department of Rehabilitation and Recreation. Functions that would continue to be centralized within government would include collective bargaining, bulk purchasing, medicare administration and recruitment of health personnel (Health Care Study Group, 1973: 154).

The model of regional health boards put forward by the Health Study Group was based on the desire to deliver services more effectively and efficiently. The objective of creating a regional health pilot project in central Newfoundland was laudable as a means of studying the effects of a new management method. However, the pilot project was never started and the desire for regionalization of health care fell off the government’s agenda. While the health system was not yet in a fiscal crisis, there were factors coming into play that would create much more severe

problems in the 1980s. We now turn to the genesis of significant reforms that laid the foundation for regionalization in the 1990s.

PART THREE: THE ROAD TO REGIONALIZED HEALTH CARE

Significant efforts toward restructuring and reforming health care delivery in Newfoundland and Labrador began in earnest with the creation of a Royal Commission by the Peckford government to study the reasons for increasing hospital costs. The *Royal Commission on Hospital and Nursing Home Costs* was established in April, 1983 with the mandate to evaluate the reasons for increasing costs in hospitals and nursing homes and how efficiencies could be created within these institutions (Executive Summary, 1984: 1). Province wide consultations with health professionals and hospital managers produced a total of 232 recommendations, the majority of which have since been implemented (Botting, 2000: 11). The Commission's main recommendations included hospital closures, rationalization of health services and multi-member management of institutions on a regional basis (see recommendations 4.4, 4.5, 4.110, 4.116 in Executive Summary, 1984: 16-17, 49-53). However, regionalization was not formally adopted. In fact, the St. John's Hospital Council, charged with establishing a restructuring plan for the capital region, suggested amalgamation of several institutions would cost nearly \$300 million. This proposal was rejected but several years later the government decided to close an acute care facility and relocate the children's hospital to a new site (Barrett, et.al., 2003: 3; Botting, 2000:14)¹.

Beginning in 1990, comprehensive health restructuring began in Newfoundland and Labrador. At a Health Ministers' conference, regionalization emerged as a potential solution to combat escalating hospital costs. In 1990, a nationwide recession struck Canada that resulted in fewer transfers to the province from Ottawa to pay for health care. As well, in 1992, the collapse of the northern cod fishery decimated employment in Newfoundland and Labrador and severely handicapped the province's ability to pay for basic services. The Wells government established a Resource Committee to review the state of the health system in 1990. Members of this committee were drawn from the Newfoundland and Labrador Medical Association, the Newfoundland and Labrador Hospital and Nursing Home Association, the Association of Registered Nurses of Newfoundland, the Faculty of Medicine at Memorial University and the provincial Department of Health (Botting, 2000: 11). The committee recommended that:

- §resources should be transferred from certain sectors into other more critical areas;
- §all programs funded by the Department of Health be reviewed;
- §quality of health care should be the first priority in the decision-making process, and
- §service duplication should be addressed (Botting, 2000: 11-12).

A number of groups that participated in the Resource Committee such as ARNN were

¹. The institutions referred to include the Salvation Army Grace Hospital (closed in 2000) and the Charles S. Janeway Children's Hospital which was relocated from Pleasantville to the Health Sciences Complex in 2001.

disappointed with the recommendations adopted by government. As Botting notes, “it appears that Government adopted these measures as part of a cost-cutting reform agenda instead of as part of a commitment to making the system more accessible and equitable” (Botting, 2000: 12). The urge to embrace regionalization as a panacea for rocketing health care costs was driven primarily by fiscal concerns not the long-term improvement of the system. For example, in the 1992 provincial budget, it was announced that 450 acute care beds would be eliminated along with 850 jobs as a means of reducing hospital and health costs.

Along with regionalization of health care, the province adopted several other strategies for combating rising expenditures. These included a focus on the population health model, an integrated approach to health care delivery and a shift from hospital to community level care. In Newfoundland and Labrador, hospital restructuring actually started in the 1980s when the rural cottage hospitals were either closed permanently or transformed into community health clinics. Many of the old cottage hospitals were in decrepit condition and would have required massive amounts of capital funding to meet existing architectural standards. While closure seemed logical, such a practice had deleterious effects on the local communities who depended on these institutions for basic health care (Botting, 2000: 14). In St. John’s, when the Hospital Council recommended that the cost of restructuring would be \$300 million, the Minister of Health rejected this and instead suggested that the Janeway be relocated to the Health Sciences Complex.

The key strategy adopted by the provincial government dealt with the establishment of regional health boards. Several health care groups who were part of the Resource Committee endorsed the concept as a means of creating efficiencies in the health system. For example, The Newfoundland Hospital and Nursing Home Association published its report *Matching Realities and Dreams: Report of the Health System Funding and Delivery Committee* in 1992. The Committee chair, Sister Elizabeth Davis, noted that the purpose of the report was to identify the issues affecting the quality and cost of health care in the province. Among the many recommendations contained in the report was a strong endorsement of regionalization. The Committee recommended that:

- the Department of Health adopt regionalization as a long-term goal;
- criteria be specified to determine the best method to combine institutions so that regional health boards can be created in an impartial manner;
- the Department of Health undertake an evaluation of multi-unit management practices to identify what works and what does not, the methods of implementation used and how future mergers should be executed;
- when mergers do occur between health institutions with different functions, special care be taken by the new boards to be open minded about different philosophies and approaches found, and
- new regional boards created by government be given more autonomy than the former hospital boards through program and service delivery standards monitored by the Department of Health (Newfoundland Hospital and Nursing Home Association, 1992: 54).

Members of the Committee were very much aware of the potential advantages and disadvantages

associated with regionalization. The Committee's advisory board, chaired by former Memorial University President Arthur May, reviewed the experiences of four other provinces who had embarked on the road to a regionalized health system (British Columbia, Alberta, Saskatchewan and New Brunswick). Advantages associated with regionalization include

“a reduction in unit costs due to economies of scale, mostly in small to medium sized facilities; increases in quality of care, due to improved potential to attract specialists; and greater justification for specialized administrative services, such as data handling, in-service education and employee group benefit packages” (Newfoundland Hospital and Nursing Home Association, 1992: 49).

Disadvantages of a regionalized health system include diminished community involvement, the potential for closing institutions in rural and remote areas, the creation of a larger bureaucracy or another layer of bureaucracy less responsive to people's needs and a decline in employment.

Regionalization became a reality when Chris Decker, then Minister of Health in the Wells government, announced that the number of hospital boards across the province was to be reviewed. As part of the changes to the province's *Hospital Act*, Decker appointed Lucy Dobbin (a former CEO of St. Clare's Hospital in St. John's) to chair a commission to review how hospital boards could be collapsed. In March, 1993, the *Report on the Reduction of Hospital Boards* was released. The considerations guiding the reduction of hospital boards included the following:

- §how reductions would affect quality of health services;
- §opportunities for improving the coordination of acute and long term care services;
- §continued participation by publicly appointed trustees to have a voice in regional health boards;
- §efficiencies and best practices for using scarce fiscal and human resources and
- §ability to take advantage of economies of scale provided by alternate models of governance (Dobbin, 1993: 1).

Based on consultations held across the province, Dobbin issued ten recommendations for government; most were formally adopted. The recommendations are as follows:

1. An education program needs to be adopted to explain changes to the public with respect to the delivery of health services.
2. The Janeway Child Health Centre and the Children's Rehabilitation Centre be merged and one health board for all acute care institutions in the St. John's metropolitan area be created.²

². The institutions include the Janeway Child Health and Children's Rehabilitation Centres, the General Hospital, the Grace Hospital, St. Clare's Hospital, the Waterford Hospital and the Dr. Walter Templemann Hospital on Bell Island.

3. In the implementation of recommendation number 2, ownership issues associated with both the Grace and St. Clare's hospitals be addressed whereby the owners of these facilities (Salvation Army and the Congregation of the Sisters of Mercy) appoint two representatives to the new health board and each owner have as a right the ability to appoint a senior management person for their facilities.
4. Governance in the Eastern health region be made up of two boards: one responsible for facilities on the Bonavista and Burin peninsulas and the other for institutions in Carbonear, Placentia, and Clarenville.
5. Two boards be created for the Central region: one in the western part of the region and the other in the eastern part. New regional boards should be established rather than continuing a multi-management arrangement and that sometime between 1996 and 1998 the two boards be combined into a single structure.
6. The Western region include Port Saunders and that the region be given time to have a transition team plan to implement a smooth transition with a target date of September, 1993.
7. One health board be established for the Northern Peninsula and Labrador.
8. The mandate of each health board must be clearly stated. A mandatory training program must be made available for staff making up the new boards. Board membership should be sensitive to regional considerations, types of services involved and have some experienced members. Finally, the principle of trusteeship be maintained for the new boards and that trustees be sufficiently compensated for personal expenses.
9. Each new board's operations will be monitored by government on a continual basis and that formal evaluations occur at three and five year intervals.
10. In regions where there is only one nursing home outside the board's authority, Government move as quickly as possible to have that facility join. A formal review of nursing home governance should be carried out as soon as possible.

In light of the guiding principles noted above, Dobbin suggested that regionalization would offer several advantages. First, overall health planning for a region by a single board would be preferable to planning being carried out by individual hospital boards. As Dobbin stated,

“It allows for one body to determine the needs of the area, assess the present level of service, eliminate duplication or inappropriate services, and apply the health dollars available in the most appropriate place” (Dobbin, 1993:15).

Second, Dobbin noted that regionalization allows for coordinated health care especially between acute and long-term facilities and needs. Third, the role of trustees would be preserved within a regionalized health system. While there may be fewer opportunities for volunteers to participate, the new governance structure would benefit from the experiences of trustees in the health

system. Finally, regionalization by itself will not necessarily save resources. Simply reducing the number of hospital boards will not have a causal relationship to health care spending reductions. However, savings can be realized when reorganization occurs that allows for services to be integrated and coordinated (Dobbin, 1993: 17). Dobbin's report recommended the creation of six institutional health boards, two integrated boards, four health and community services boards, one nursing home board and the provincial Cancer Treatment and Research Foundation Board. Boards began to assume their authority between 1994 and 1996.

Dobbin's report was not without its critics. At the top of the list were the institutions in St. John's. Health restructuring was most pervasive in this region. In 1995, all eight institutions in the metropolitan area were amalgamated under the Health Care Corporation of St. John's (HCCSJ). As well, the HCCSJ assumed responsibility for three schools of nursing, Central Laundry facilities and the Regional Ambulance Service (Botting, 2000: 16). Eventually, two of these institutions were merged and relocated and one acute care facility was closed. The administration of institutional long-term care was separate in St. John's as compared to the other regional boards. The HCCSJ relied on well-developed management techniques and a strategic plan that fostered organization, clinical and site integration (Barrett, et.al., 2003:3). The HCCSJ undertook an education campaign to disseminate information to the general public, staff and unions. For example, integration of clinical services across sites was completed in 1996 and a significant reduction in management positions was realized as a result of amalgamation. In regions outside St. John's, the experiences associated with regionalization were slightly different. Between 1994 and 1996, new boards were created across rural Newfoundland. In every case, an immediate consequence of the new boards being established was a reduction in management staff (Barrett, et.al., 2003: 4). Most of the new boards adopted organizational and management styles that brought forth both centralization and integration across institutions. However, one challenge for rural boards was rationalization of clinical services given the tremendous geographical dispersion in some of the regions. Some rural boards also experienced unpleasant political effects as a result of regionalization. Historic and regional rivalries among communities as well as institutions often contributed to a climate of decision-making that was hostile rather than cooperative. For example, in the Western Health Care Corporation, a review undertaken in 2001 noted problems such as conflicting messages and a lack of sufficient funding from the province; the inability of the regional board to confront inappropriate provincial and municipal interference; the lack of support among physicians to the regional model of health delivery, and politicians using the regional health model to put forward their own agendas (Barrett, et.al., 2003: 4). In the Peninsulas Board, there was widespread public resistance to the regional plan drawn up by the Department of Health beginning with the Bonavista peninsula in 1997 and followed by the Burin in 1999. A task force established by the province to deal with public concerns resulted in a series of recommendations designed to strengthen the administrative relations between the two areas.

PART FOUR: REGIONALIZED HEALTH CARE BECOMES A REALITY

Like several other Canadian provinces, the government of Newfoundland and Labrador adopted a regionalized structure for health care delivery as a means of reducing costs and creating efficiencies within the health system. Initially, the government established institutional health

boards across the province. These boards would be responsible for providing hospital and other institutional services to patients. The boards would oversee the disbursement of funds to all institutions under their management, be responsible for hiring staff, engage in coordination of services and be accountable to the Department of Health. The boards themselves would be composed of volunteer members and permanent staff. Volunteer members were to be appointed by the provincial government and compensated for out of pocket expenses only. It is interesting to note that there was little demand voiced for having board members elected by the general public as was the case until recently in both Saskatchewan and Alberta. One reason for the lack of interest in an elected board structure is the fact that Newfoundland and Labrador has not historically had much experience with municipal governance. The following quotation (originally published in 1946) illustrates the lack of interest in having elected Boards of Health:

“An effort is being made to institute a Board of Health in every district where there is a Cottage Hospital, and a Nursing Committee where there is a public health nurse. The Board, or the Committee, under instructions from the Department of Public Health and Welfare, endeavours to improve public health conditions, and to collect and disburse the insurance premiums. In 1931 the Health and Public Welfare Act made provision for the election of Boards of Health, but, as local government bodies are practically unknown outside St. John’s, no communities seized upon the privilege of electing Boards of Health. Instead, where a Cottage Hospital or a nursing station has been built or a public health nurse stationed, boards or committees have been brought into existence by appointment. Sometimes a group of citizens will get together and constitute themselves a Board or Committee; sometimes the leading citizens of a district will have to be asked to assume the responsibility” (quoted in Health Study Group, 1973: 27).

In 1993, the government further announced the creation of a second type of health board known as Community Health Boards. These boards were charged with providing a broad spectrum of community health services including health promotion, health protection, single access points of entry for home care, home support services, entrance to personal care and nursing homes, drug rehabilitation services and mental health services (Botting, 2000: 17). A total of four Community Health Boards were established. Two additional health boards were designated as integrated boards. These boards, located on the Northern Peninsula and Labrador, combined the services of both the institutional and community health boards. The establishment of community health boards by government reflected the shift in thinking with respect to health care from acute care to wellness and prevention. In other words, instead of the health care system simply treating illnesses, medical professionals began to lobby for wellness and promotion campaigns to get people to change their behaviours as a means of reducing the incidence of particular diseases. The boards’ overall objective was to promote “individual responsibility for one’s own health” (quoted in Botting, 2000: 17).

In April, 1998, the government announced that the Department of Health would be given responsibility for child welfare, community corrections, family and rehabilitative services. These responsibilities were transferred from the provincial Department of Human Resources and Employment. As a result, a new Department of Health and Community Services was established to reflect these changes. The shift in responsibility reflected the desire of government to link health wellness and promotion to a determinants of health model and to allow for more efficient

provision of services on a regional basis.

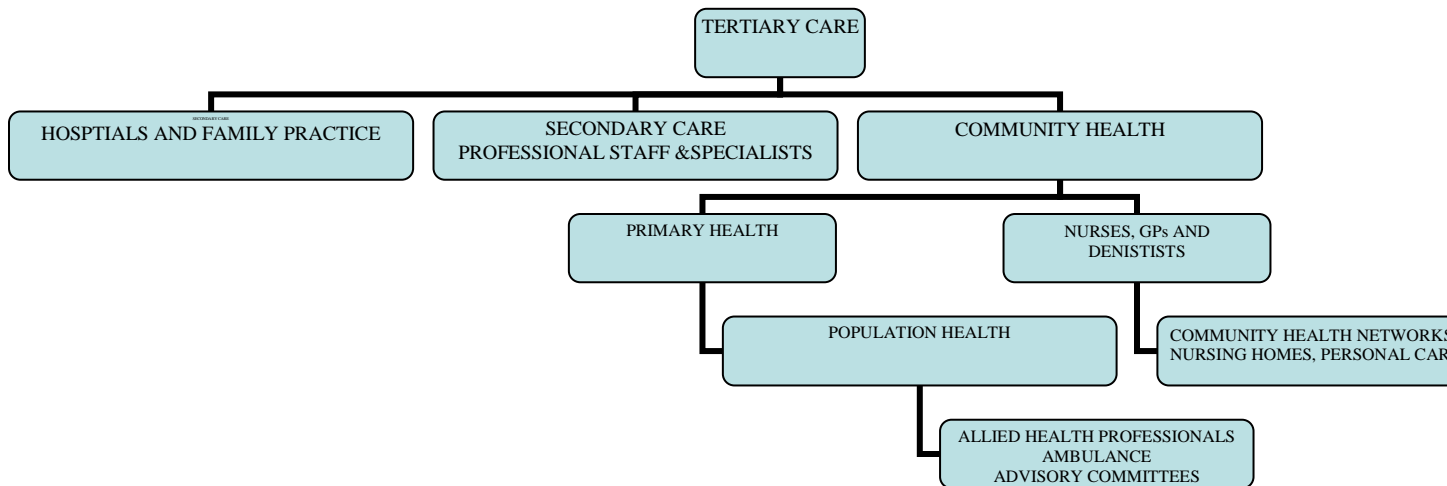
The health boards in Newfoundland and Labrador are collectively represented by the Newfoundland and Labrador Health Boards Association. This organization began in the early 1960s as the Newfoundland Hospitals Association. In 1987, the group changed its name to the Newfoundland Hospital and Nursing Home Association to reflect the inclusion of nursing homes. In 1995, following the establishment of a regional health system, the group's responsibilities were broadened to include the boards. Between 1995 and 2000, the group's mandate was expanded to cover child welfare, family and rehabilitation and youth corrections as well as the community services under the aegis of the community health boards. In April, 2000, the group became the NLHBA (Botting, 2000: 19).

The establishment of regional health boards by the provincial government was a harbinger of change to the health system. Most significantly, policy makers embraced a "determinants of health" approach to explain the need for and access to services as well as developing programs to encourage better lifestyle choices among the population. The NLHBA, in its former incarnation as the Newfoundland and Labrador Health Care Association, played an important role in the development of the current health care system in Newfoundland and Labrador. The following list of assumptions and principles was used as a guide to redesigning the health system in the province:

- § consumers are active partners in health planning, delivery and evaluation.
- § a greater emphasis is placed on population health.
- § individuals must have greater autonomy over decision-making as it relates to their own health.
- § there should be more community health services and referrals with a multidisciplinary approach to provide balance within the system.
- § the Charter of Rights and Freedoms must be kept in mind in terms of resource allocation.
- § all health services and programs are accessible to the intended patient groups.
- § the concept of regionalization must undergo continuous refinement with a commitment to health programming based on population health status.
- § a comprehensive human resource plan must be developed.
- § health care partners (decision makers, participants, planners) are educated with respect to quality of life issues which becomes the fundamental theme for determining health quality.
- § evidence based decision making determines programs and services to be delivered.
- § comprehensive provincial standards such as manageable wait lists, distance travelled to access health services and so on must be developed.
- § all government policies are to be analyzed for their health affects with policies geared toward the promotion of healthy outcomes (Newfoundland and Labrador Health Care Association, 1997: 2-3).

From 1994 to April, 2005, the health system in Newfoundland and Labrador was organized in the following manner.

TABLE 3 ORGANIZATION OF HEALTH SYSTEM IN NL 1994-2005



Community Health and Secondary care are found in every health region of the province. Tertiary care is located in St. John’s and is managed by the Health Care Corporation of St. John’s.

With respect to governance in a regional health system, the Newfoundland and Labrador Health Care Association noted the following:

- § boundaries for institutional and community health boards are the same.
- § if there is a need for more than one board in a region, all boards should cooperate and act as a single entity to provide the best possible care.
- § overlapping services between boards must be eliminated unless deemed absolutely necessary.
- § regional boards must reflect the population and geography of their areas.
- § other social programs affecting health should be linked with the health boards in an appropriate way.
- § competition among boards is not acceptable.
- § physicians and family practice specialists are to be integrated into the regional health framework.
- § interested groups including health providers, consumers, and educational institutions are key parts of the decision-making process (Newfoundland and Labrador Health Care Association, 1997: 7-8).

Regionalization, at least in its 1994-2005 form, reflects the move from a health system focusing on cure for acute conditions to one where the emphasis is on prevention, promotion of lifestyle change and participation from key groups.

PART FIVE: PLUS ÇA CHANGE, PLUS C'EST LA MEME CHOSE?

When regionalization was embraced by the Wells government in 1993, the primary reasons given were to provide improved continuity of health care and to avoid costly duplication. The main driver behind regionalization was fiscal; that is, the government wanted to reign in health spending without disruption to basic service delivery. Hubert Kitchen, Minister of Health when the Dobbin Report was endorsed, noted that “the new board structure will provide the opportunity to enhance patient care services and will allow us [the government] to improve efficiencies in resource utilization. In general, this approach will provide a climate for more innovation and cost effective delivery of quality health care services “ (quoted in Botting, 2000: 21). However, what has happened since the health boards were established belies Minister Kitchen’s optimism. The Department of Health and Community Services has transferred responsibility for health care delivery to the boards while monopolizing policy making. Before the boards were in place, the Department directly managed nearly twenty cottage hospitals. These were replaced or closed down entirely with the advent of regionalization. While the government does retain some degree of control over the health boards with respect to budgets and appointments, the boards are still deemed to be primarily responsible for providing services to patients.

In 1997, the Tobin government undertook an evaluation of the province’s health system as part of its effort to create a Strategic Social Plan for community services. A Provincial Health Forum was held in May, 1997 and chaired by former Premier and current opposition leader Roger Grimes. The forum was established as a response to the changes that were precipitated by the new health boards, patient concerns and staffing considerations. Some of the key issues that emerged from the Forum included a more integrated health system; the need to address physician shortages in rural areas; emergency room physician shortages; workload for front-line health

workers; wait times for cardiac surgery and other medical procedures; the pace of health care reform in the province and a desire for more coordination and cooperation among health professionals; an emphasis on prevention and public education and more evidence based decision-making (Botting, 2000: 21-22).

The government's response to the issues raised at the Forum were as follows:

- §a better compensation package for emergency room doctors (cost of \$5.3 million);
- §implementation of a workload management system for nurses;
- §the creation of primary service and teaching units in Twillingate and Port aux Basques;
- §a call for the formation of an advisory committee on health issues, and
- §an additional \$20 million for the health boards.

The government's strategy was largely reactive and myopic rather than strategic and proactive. Why? Several reasons come to mind. First, governments desire short-term benefits to enhance re-election prospects and to go before constituents and claim that action is being taken on a specific issue. Second, the lack of fiscal capacity in the province means that long term planning for health reform is more difficult to execute. Third, key health groups have been very critical and often vocal in their opposition to the government's plans for reform. As Botting notes, the NLMA, the Newfoundland and Labrador Nurses Union and the ARNNL have all been critical of primary health reform. Physicians are concerned about maintaining their position as gatekeepers to the health system; nurses have long argued for an enhanced role in the health system. Both groups argue that reform requires both planning and resources. For example, the NLMA has stated that the cost effectiveness of primary health care reform provided by doctors must be studied and evaluated before any action is taken (Botting, 2000: 23-24). Nurses have been disappointed that they are not seen as key participants in the reform process. To remedy this situation, the NLNU commissioned a study on primary care reform in 1995. The study was conducted by Dr. Michael Rachlis and Carol Kushner. The study concluded that if nurses, doctors and other health professionals worked cooperatively in teams at the primary care level, then patients would benefit from improved health services. This became known as the community health centre model where nurses could play a more central role in the delivery of health care at the point of introduction. In the end, the reform process has been reactive. As Botting states,

“The reform process has been characterized by a lack of consultation and a lack of planning, according to many groups of health care professionals and community groups. In that regard, one of the Department's most obvious shortcomings has been that it has not had the time or the resources to produce an annual report since 1995, which raises serious questions about accountability” (Botting,2000:23).

A more recent review of regionalization with respect to acute care in Newfoundland and Labrador contained several important findings on the effects of reform. The study found that

- §regionalization alone does not completely explain cost drivers and may not be an effective way to control health costs;

- §opportunities for the further integration and rationalization of services and institutions exist within the health system and strategic planning and leadership are crucial to control costs;
- §hospital closures within a context of regionalization and program management may not necessarily lead to a deterioration in healthcare provider attitudes, patient satisfaction and quality of care;
- §ways of keeping healthcare workers in the system include more money, efforts to improve work load, overtime and productivity, reducing unnecessary demand for health services and a reduction of health need due better population health;
- §targeted interventions offer a more effective means to improve use and efficiency as well as patient satisfaction;
- §access to acute care beds is a tremendous problem (Barrett, et.al., 2003:i).

Regionalized health care is clearly not a cure for reducing health spending in the province. As well, there is not enough public education or awareness of the major changes that have occurred in the health system (Newfoundland and Labrador Health Boards Association, 2002:13).

The most recent round of reforms connected to regionalization formally began in 2003 when the Progressive Conservative Party of Newfoundland and Labrador, led by Danny Williams, won the provincial election defeating incumbent Premier and Liberal Roger Grimes. Williams laid out his party's policy platform in the "Blue Book." Many of the proposals were targeted toward reducing the debt and deficit of the provincial government. The Department of Health and Community Services was not exempt from the desire to reduce the size and expenditure of government. The initial announcement concerning changes to the regional health boards came on March 30, 2004 following the introduction of the provincial budget. The first of four initiatives to be implemented concerned regionalization:

"Creation of regional integrated health authorities. Board integration will occur in the coming months, providing integrated and smaller corporate structures to better reflect the population base of our province" (Department of Health and Community Services, NLIS 19: March 30, 2004).

The move toward reducing the number and functions of health boards began informally in the late 1990s under the previous Liberal administration. During the town hall meetings held to gather data for the Strategic Health Plan, one of the key talking points concerned the number, function and mix of health boards. As will be noted below, several participants in our project commented that the genesis of the most recent changes took place around 1999-2000. On September 10, 2004, former Health and Community Services Minister Elizabeth Marshall announced the changes to regional health care in the province. There would be four integrated health boards: Eastern (Avalon, Burin and Bonavista peninsulas); Central; Western (including the Northern peninsula) and Labrador-Grenfell. According to the Minister,

"creating fewer, more accountable health authorities is a necessary step in renewing our health and community services system and meeting client needs. Fewer regions mean less administration and more opportunity for collaboration. Integrated boards will have the ability to

focus on the full continuum of care, from community care to acute and long-term care, resulting in better service for clients” (Department of Health and Community Services, NLIS 2: September 10, 2004). The table below outlines the key features of each new integrated health authority.

TABLE 4 REGIONAL INTEGRATED HEALTH AUTHORITIES

REGION	POPULATION	HOSPITALS	COMMUNITY HEALTH CENTRES	NURSING HOMES	OTHER *
Eastern	295, 145	7	6	12	2
Central	100, 926	2	6	5	0
Western	82, 034	2	4	3	0
Labrador- Grenfell	40, 516	3	14	2	0

* These include the Dr. H. Bliss Murphy Cancer Centre and the L.A. Miller Centre.

Following the announcement of the new board structure, a transition stage was initiated to begin the amalgamation of the former institutional and community services boards. The Department hired Ambrose Hearn, a former deputy minister of health for the province, to help with the transition. Government announced that new board chairs and Chief Executive Officers would be hired. The new board chairs were announced in late November, 2004 and full board representation was complete in early January, 2005. The new board CEOs were subsequently named in January, 2005 (see Appendix A for a complete list of CEOs, Board Chairs and Board members).

Regionalization of health care is barely a decade old in Newfoundland and Labrador. There have been significant changes with respect to restructuring and closing of institutions and transfer of services within the system. The boards, whether institutional or community health, have bore the brunt of these changes and have often been criticized and vilified by the public for apparent failures. However, a number of issues with respect to regionalization will need to be addressed including the number of boards across the province, whether board members should continue to be appointed, whether boards should have institutional mechanisms in place for greater cooperation and sharing of resources and the degree of transparency with respect to evidence based decision making. A significant part of our project will examine these and related issues to determine whether the current regional health care structure is indeed suitable for a geographically dispersed population such as that found in Newfoundland and Labrador. We now turn to the voices of those persons who shaped regional health care as it evolved since 1990.

The final sections of our paper will review participants’ answers to a series of questions focusing on the evolution of regionalized health care in Newfoundland and Labrador since 1990. The emphasis is on reform that occurred in the 1990s. However, several participants also discussed the most recent (2005) reforms that have created the four integrated health boards in the

province. The questions posed are organized under three rubrics: the public agenda, the decision agenda and policy choice. The public agenda is concerned with how regionalization was discussed and reported by the mass media, government reports, Royal Commissions, health focus groups and the like. The decision agenda reflects the processes in which government decided to act or not to act. In the case of regionalization, the government chose to act to establish a regionalized system. Policy choice is concerned with the alternatives available to decision-makers that shape how the policy evolved.

PART SIX: REGIONAL HEALTH CARE – THE PUBLIC AGENDA^a

Our first question asked participants to recall when the issue of regionalized health care first appeared on the provincial government's radar screen. In nearly unanimous fashion, participants said the early 1990s corresponding to the decision taken by the Wells government in the wake of the recession and the cod moratorium. Others who have a longer history of association with the issue suggested that regionalization had its genesis with the *Royal Commission on Hospital and Nursing Home Costs* which reported in 1984. As noted above, discussion of the issue goes as far back as the mid-1960s. A more interesting question asked has to do with who was involved in raising and bringing forward the issue of regionalized health care. Participants identified a number of key players who raised the issue including former Premier Clyde Wells, former Health Minister Chris Decker, Lucy Dobbin, Joan Dawe, the Departments of Finance and Treasury Board, the St. John's Hospital Council and a Cabinet level Resource Committee.

Mr. Wells was the Premier at the time - and he took this very seriously; and under Chris Decker's leadership, they were going to start looking at this. And so, at the time, they gave an indication they were going to move to regional governance, but they brought Lucy Dobbin in then to do her report and the report wasn't will we go to regional governance; the report they asked her to do was how we would do that.

So she set up a process and she had an advisory council. She talked to all the [hospital] boards in the province. She made her report to government and then in November of '93 they actually announced they were going to the regional structure.

(3)

To implement anything in this province on a scale such as regionalization, Treasury Board approves it, not the Ministry [of Health]. And Treasury Board will not approve it unless there was savings; but when the politician gets up and talks about the new reform, they're always going to say that it benefits the public. (7)

One of the key people who was involved was Joan Dawe in the early 90's. She was then the Assistant Deputy Minister in Health and her focus was on one hospital regionalization to bring that together in a different way than it had been in the past and she had been, before that, responsible for the hospital council in St. John's who had been working for years to bring together the hospitals in St. John's under one regional structure. (12)

It was the Executive Council and Treasury Board from a dollar and cents point of view that got the whole thing [regionalization] started. (18)

Mr. Decker convened what they called a Resource Committee, and we'd usually meet on weekends because of his desire not to put people out. There was representation from the Association of Registered Nurses, the Newfoundland and Labrador Medical Association, the Medical School got representation, some [hospital] board members and some... also executives in the health administration. And the minister convened a series of meetings and looked at the system and came up with some principles. I think there was about 8 or 9 principles which, again... I can't remember them now but they're written up. There's documentation in the Department of Health that looked at some principles - one of the key principles, obviously, was the interconnectiveness of the health care system was almost like a river. (24)

Well, fifteen years ago, it seemed that it [regionalization] was externally driven as opposed to internally. Well, now I have to take a step back. I'm reflecting on this. Fifteen years ago in St. John's, there was an entity known as the St. John's Hospital Council, and they were tasked with coming up with a strategic plan with respect to the future of hospitals in St. John's, and they got into all sorts of combinations of structures and many of which meant the closure of some sites and the rebuilding of others; and I think from that perspective, they went through the planning process. There was a realization there that we could be doing more things together; but, now that wasn't regionalization. That was a merger. So that was really focusing in on the economies of scale issue. So only economies of scale were what was being thought about more so within the organization. I think that the concept of trying to pull the full continuum together, which is what I would describe as the true regionalized model, was coming more externally at that point in time because when we eventually restructured in 1995, St. John's merged only, but Labrador regionalized because they had community long term care and acute under one. So it really was something that was being driven from outside our organizations at that time. (27)

What emerges from the above statements is that the key individuals who brought forward regionalized health care were located inside government or within the hospitals and health institutions themselves. There were external factors that entered into the mix including efforts to regionalize in other provinces and reductions of transfers to have-not jurisdictions by the federal government. However, the development of regionalized health care took on very much a “made in Newfoundland and Labrador” tint as it evolved.

Another feature concerns the views given to regionalized health care by participants. How did these individuals view regionalization? Was such a policy necessary? Which persons brought competing views to the table and how were these constructed? The best way to summarize our participants' feelings is to describe them as plural and diverse. A sampling of views is reproduced below.

Well, first of all the public was not involved in this [regionalization] at all. It was a non-issue for the public; it really was within the system. Everybody, except the General Hospital in St. John's, resisted regionalization. The Sisters and the Salvation Army, because they privately owned their facilities, did not want to lose them, which is what regionalization would've meant to them as they saw it at that point. The Janeway, and to a lesser extent, the children's rehab, certainly did not want to be brought into any system that involved adults because they felt they would lose out to the adult system. The Waterford Hospital was finally coming into its own. It had been a quite archaic structure. Under new leadership it had really started to come into its own as a good place in mental health delivery, and they were terrified that if they were brought into a regional structure, they'd lose yet again to tertiary acute care. The only organization that favoured this was the General Hospital. They were the biggest so they knew they couldn't lose. (3)

Newfoundland with its fiscal environment is much more challenging to really look at innovations sometimes when it comes to reform, and we can't do what other provinces can do because we don't have that extra money. So there's two things with that. One - it really limits your options; and two - usually, anything that does look at reform is looking at cost savings right across the board.

When I saw the focus for regionalization it was autonomy that boards would have to do what they felt best for their community. They were at ground level. They knew what their communities would need with respect to services. Therefore, if they got block money and removed the Ministry from the decision making, the communities felt empowered by that, because your boards will never be community leaders.

What is the basket of services we're going to provide? You only have this amount of money. That worked well for the government, of course, because it removed the politicians from the bad decisions. (7)

Local hospital boards were very concerned as were their communities because our voices are not going to be heard and hospitals are going to close. And there were some cottage hospitals that were no longer viable. They didn't have the same status they had before. They didn't have the same level of service so some of those things, in fact, did happen but that was also part of trying to create efficiencies. So there was certainly that voice at a very local level and those people going to their politicians saying we don't really think that this is going to work for us. As we continue to get bigger and bigger, our local issues don't get heard and we're losing things in our community. (12)

Regionalization: in today's environment, I think to most people it has become another buzz word for rationalization. (13)

There were a lot of people concerned, and there still are a lot of people concerned, particularly the concerns around the issue of community issues being dominated by the institutional agenda, by the overwhelming budget issues related to the institutional sector, and I think that's always been there. (14)

The 90's really caused a change in people's thinking. I mean, that was such a cut and chop decade and everybody was looking for every possible way to save a cent so that then we all started to turn our eyes to where is there duplication, are there inefficiencies? (16)

I was an advocate of regional health care at the time, believe it not. I was strongly in favour of regionalization and believed that it could provide better services to consumers of health care. I knew there was going to be significant pain because up to the 1990's and particularly in the organization where I worked, which was provincial in scope, being the Waterford they weren't great advocates of regionalization, but I believe we needed to provide service closer to where people lived and I think we could coordinate it better, and that was my perspective at the time. Communities that had health care facilities in them brought competing interests. I think different specialty hospitals or services, I think long term care organizations, mental health organizations and hospitals brought a different perspective. I think some concerns were given by particular providers, who were concerned that regionalization would liquefy what they were doing and also I think, somewhat, their power base at the time. (20)

My own position was that it [regionalization] was something that, theoretically, sounded better instead of stand-alone entities and all the silos doing their own thing, probably not networking as effectively as they could. (22)

I think the attention that it got were for some communities who felt, by losing their local hospital board, they were losing, you know, control over their health and they would suffer reduced services, less local autonomy and those types of things. (25)

It [regionalization] wasn't seen at the end as being something better. It was cutting. It was saving money and so communities and interest groups were going to be hurt by this. Government is getting out of the business and they're downloading to health boards; but in the process of doing that, communities will be hurt. (26)

Unlike other provinces, when we started to look at regionalization again in the 90's, I was a very strong proponent of keeping the community side from the institutions because in our province and not unlike other jurisdictions we were very weak and vulnerable on the community side. Very few resources and attention were paid to wellness, to lifestyle issues and the importance of these in addressing health

problems such as cardiac disease and cancers. (28)

For many of our participants, the “losers” in terms of regionalization appeared to be rural communities and their health facilities. Regionalization itself was defined and framed by those persons inside the policy community: politicians, senior civil servants, members of health professional groups, health institutions and best practices from other jurisdictions. Ordinary citizens and community groups were not privy to the debates defining the issue.

Regionalization is the only major health reform that has taken off in Newfoundland and Labrador. Other areas where reforms have occurred, such as wait list management, pharmaceuticals, needs-based budgeting and health human resources have not enjoyed the success that regionalization has in the province. One possible reason for this is that regionalization did not adversely affect or harm physicians’ hegemonic status and autonomy within the health system. Certainly other reforms such as primary health care and wait list management do affect physicians in direct ways. Regionalization and the creation of health boards in Newfoundland and Labrador did not affect physicians in the same manner as other health professionals, especially nurses.

The doctors were an interesting group because I think what happened... first of all, it only mattered to the specialists. It did not matter to the family docs because unfortunately, up until today, primary health care never did get reformed. This was all about secondary and tertiary care. So that's the first thing. The second thing, as far as I could see, some of the more powerful doctors in St. John's wanted it to happen for reasons that they later regretted, but they honestly thought that if there was a group it would be better. Now the individual groups of physicians - the Janeway physicians, for example, I would not think were very powerful on their own and there weren't enough of them to make a difference, I don't think, within the NLMA. And, you know, like it seems to me - and I don't know this to be so - but it seems to me at that time that the family docs were really more in control of the NLMA agenda and this wasn't an issue for them to be blunt. (3)

I find the physicians are quite autonomous to politics anyways in that as long as their remuneration is there and they feel that this is appropriate for them when on salary or fee for service, regionalization didn't impact them because they really are individual business people. They may work through the board but they're paid through another system. Fee for service is paid by MCP and not through the board. (7)

Well, I think on a day-to-day basis, most physicians find regions to be irritants; the regional authorities to be more irritants because they're really sort of the government's lackeys in many respects, and their job is to introduce measures to help cut costs or whatever and translate that to the everyday physician in terms of this headache or that headache or what have you. The other thing is in terms of the

broader policy development and the broader sort of safety factors for, say, the profession, they kind of look to us. We basically work around those regions. Well, what happens is because there aren't any standardized sort of administrative practices between regions, what ends up happening is each region makes up different rules, and what you end up having is competition between regions. A good example would be, say, Central West and Central East which are now... it's going to be interesting because now they're under one authority; but until that happens - which is just happening now - what you have is poaching, right? The guys in Central West will go into Gander and say, well, you know, if you come work for us, we'll shovel... we'll do your driveway for free and we'll give you this... (9)

I don't think they [physicians] were as politically opposed, but their answer to it was, well, we'll just stay where we are and do our own little piece of work, which meant at the end of the day our hospitals suffered in terms of having those services and having that kind of continuum care available to the patients of the hospital. (12)

The physicians actually have been the people who have held themselves more apart from the system than the other health professionals. Other health professionals have seen... worked with their relationship with each other and the public and the physicians are still working on that, you know. And there's a certain amount of their own initiative attached which is hard to... hard to relinquish, or even modify. But I believe they are working on it. I see the stability of the change with respect to nurse practitioners, the change in the delivery of public health care and that kind of thing. (17)

I think you had some good physician leaders who were active in a string of levels who embraced change, but you often see in clinical groups where they're doing their work - they may perceive that nothing is going to change anyway because I'm part of a delivery on the front lines and my day-to-day activities aren't going to change a whole lot. But autonomy in terms of regionalization deemed that a particular service is going to be offered from one site versus another and a practitioner was set up in an area where the corporate body didn't necessarily feel that that was the right area and you see some physicians reacting to that. (22)

Our final set of questions for the public agenda focuses on the external and internal factors or drivers that account for the different perspectives brought forward by those individuals involved in framing regionalization of health care. Participants provide a diverse array of views on the key drivers that shaped regionalized health care. Key drivers include:

- rapid increase in health care costs especially pharmaceuticals and technology (MRI, CAT Scan equipment, computer software);

- federal reductions in health care spending, transfer payments and implementation of the Canada Health and Social Transfer (CHST) in 1994;
- buy-in from individuals and groups outside of government (communities felt that regionalization of health would provide them with more control over how health resources could be distributed);
- political expedience: regionalization was a way for government to off-load its political headaches resulting from bed reductions and hospital closures to regional health authorities who would then have to answer to local communities for the cuts in service;
- lack of money and the lack of fiscal capacity in Newfoundland and Labrador;
- the fact that regionalization was adopted in other provinces and seemed to help sustain health care systems;
- changes in technology such as fax, e-mail and electronic health records allowed for better coordination and collaboration across institutions;
- the desire to realize efficiencies and economies of scale to reduce costs;
- unions; easier to deal with one bargaining unit at the regional level than several at the local or institutional level;
- lack of communication across institutions as a result of policy and institutional silos;
- isolation of health planning;
- desire to enhance and strengthen health prevention and promotion, and
- keeping the health system sustainable to at least provide basic services to the population.

PART SEVEN REGIONAL HEALTH CARE: THE DECISION AGENDA

The decision agenda focuses on the debates and discussion among decision-makers and members of the regionalization of health care policy community. The emphasis is on what happened inside government with respect to when and how regional health care was adopted in Newfoundland and Labrador. Two key items concern first, the definition of the regional health boards (including the separation of acute-care institutions from community health) and why board members were appointed by government rather than elected by the public. Second, we wondered why regionalization of health care went forward in Newfoundland and Labrador while other reforms either stalled or never took off. What was unique about regionalization that made the policy attractive to decision-makers? Our participants identified a plurality of other factors that influenced the decision agenda with respect to regionalization of health care.

At the heart of regionalized health care in Newfoundland and Labrador are the health boards. In the 1990s phase of reform, the government created six institutional care boards, four health and community services boards, two integrated boards, a board overseeing the Cancer Centre and a board responsible for nursing homes and long-term care (see Appendix 3 for maps showing boundaries). The governance structure of the boards was defined by government through legislation (see *The Hospitals Act, 1994*). Boards were required to have a Chair, averaged between 12 and 18 members in size and were responsible for providing government with an annual report detailing how their budgets were spent and various services provided to the population. All of our participants stated that the boards were top-down creations; that is, there was no public or community input to determine their

responsibilities, size or governance structures. A sample of remarks is listed below.

People who worked in the system day to day - you know, the leaders in that system - your CEO's and your executives - they had input into that and then you had people in the department who were either in the policy regime or in the day-to-day operations who were saying, these are some of the things you need to hear, and that's overlaid by the final decisions being made by politicians and some of the philosophical perspective gets lost, obviously, as you move along in that continuum up to the political realm where you still have politicians sitting around saying, okay, where is my hospital in my community or where is my service and what does that mean for my constituents. (12)

The model that was proposed came from within the Department of Health itself; and at the end of the day, we knew there was sort of cabinet direction or cabinet approval of the model, and the cabinet was actively involved in the process. There wasn't sort of just, here's our model and cabinet said yes to it. From my understanding, they were quite challenging in the process and cabinet themselves then came back and suggested a couple of alternate models and why this model instead of this model; but it was driven, I think, without the department; but at the end of the day, I mean, geography would be the... you know the practical factor that would limit or restrict what you could actually do. (13)

Oh, there were very wide consultations - existing boards, community groups, civil servants, managers within the system, providers within the system - so a pretty wide consultation process that was carried out to define the roles and the boundaries of the boards. (15)

The [hospital] boards themselves defined the process. Take St. John's as an example. There was a committee in place with 50 senior managers from the system in St. John's and they were part of the St. John's Hospital Council. They talked about what the delivery of services should be in the St. John's area. So it was, to me, government cutting the money and the system designing how to provide the services with the money that was being provided, and that's the easiest way to describe because I think if you had government documents and government bursaries, I doubt if you would find anywhere where they'll say that we've gone from whatever number of boards down to 14 boards because of dollars and cents. I don't think you would find it anywhere, but my point of view, at least, anyway - that was the 99.9% of the reason why it was done. (18)

My memory is that it was primarily a senior bureaucratic exercise in government, but I think there was consultation with some of the provider groups. At the time, I think there was consultation with the Health Board Associations and the NLMA, you know, and also the Nurses Association were also brought in. So I think there was

some consultation - the extent of which I'm not sure. My sense is that there were high level discussions going on in government, probably at a Cabinet level, which was talking about sort of the ideal number of, you know, regions within Newfoundland and Labrador, which they figured out - 6 was the ideal at the time. (20)

One of the groups would be the administrators of the hospitals and the administrators of the public health units at the time. I think government decided they needed to do something but I think it was people within the system did recognize that changes had to happen. (25)

It was a government decision and maybe once government set the big agenda and then, once the CEO was appointed, that I think that person then had some leeway in terms of process after that. I mean, obviously, the St. John's Board went with program management, which was different than any other board; but I think that was pretty much dictated from government in terms of how many people and that type of thing. (26)

The health boards were clearly creatures of government with respect to their structure, size and function. The more fundamental issue concerns the process of selecting individuals to sit on the boards that were created. The two models used in Canada for health board selection are appointment and election. Most provinces have opted for appointment; some, like Saskatchewan and Alberta, briefly experimented with elected boards. What difference does the method of board selection make to the process of regionalized health care? Academics have argued that elected boards are seen as being more democratic because citizens choose their representatives and board members are accountable to various constituencies with respect to health care access and delivery. Appointed boards are seen as being levers of government because members owe their seats to the politicians who select them. Such boards have less legitimacy in the eyes of the public because of their close connection to government. In Newfoundland and Labrador, members of health boards have been and continue to be selected on the basis of appointment by government. The main argument in favour of this method of selection is that government is able to secure a geographic, age, gender and health constituency group balance via appointment and that an elected board would be enslaved to local rather than regional interests. Our participants shared their views with respect to whether health boards should be appointed or elected. A sample is listed below.

What the discussion has been and the feedback has been is that elected boards were not working because people came specifically with their own agenda for their own group, and they couldn't engage in the discussion around what's the greatest good. I think there was consideration from an appointed board perspective that what we want to do is have representation across our region geographically because obviously you're not going to have everybody from St. John's. But we also want to look at people that have some expertise in particular areas and that they had been told from the beginning that, as an appointed board member, your job here is not to

represent your community. Your job here is to represent the issues to make this the best possible organization and provide the best possible service we can. So you have to take that hat off and wear your broader hat. So that's, I think, why that decision was made. (12)

My view of it would be to address the community's concerns about their lack of input at the regional authority level, I think or I would assume that there was a deliberate effort to go out and to ensure there were a few people who had been on previous boards so that there was some continuity or some expertise, but I would otherwise assume that people would've wanted representatives of the various communities. I would hope they're being moved towards an elective type process, but I think because of the vast geography the need to have regional representation is highlighted for sure. (13)

Interesting that the recommendation from the Steering Committee, I think, had gone forward that they [the boards] be elected, and I guess it was a government decision to reverse that. I guess they [the boards] could be more easily controlled if members were appointed. (14)

Boards were appointed because of tradition more than any debate on the issue or on any sort of considered weighing of pros and cons, I think. Basically, that's the way it was. We got to get it done. We'll keep doing that. I don't think government got engaged in much of a debate or philosophy there. (15)

Government didn't want to lose control of the health system and it wanted to give the appearance that it was going to be governed from a voluntary governance perspective. Government didn't want to lose control, and they could still gain control by having people who were primarily government appointments. So the government agenda could be translated through these appointed board members. Board membership is diverse, too. There's a different kind of culture in, for example, St. John's than there is in Central Newfoundland from Western. So in St. John's you saw more - and I know this because I worked in the system - professional people from both business and academia on the board, where as the further you got from St. John's, the more it was likely to be community members who had links to the party that was in power. (20)

For historical reasons boards have been appointed. I don't know if it was an easier process, but I know it's historical and that's the way it's outlined in the actual by-laws of organizations, and I'm not certain if that one is in the Hospital Act but I know it's part of the way government has done their business has been appointing the boards of directors. There's some challenges around that because sometimes those

appointments are certainly political in nature. So, you know, if you have elected boards then you allow an option for people also to identify those people they want to represent them in the community because they really serve as a representative of the community as well in terms of health needs. (21)

Well, our provincial government likes to have control. They really are into patronage and rewarding people who support them - always - doesn't matter what group are in.

That's one reason. They don't trust that people can make wise decisions. (23)
Our choice... I mean, we believe in elected boards, right, and we advocated for elected boards - or a combination - and I could be persuaded that a combination of elected and appointed members is best so that you make sure you get a base of expertise, that

I think you need because if the boards are true governance and they're setting direction for the organization that they're governing, you do need a certain level of expertise there, but I think also you need for citizens to be able to elect people that they believe can represent them on those boards. So I was in totally elected boards, but now I'm sort of switched to a combination thereof, but government has certainly dictated that agenda, I think. (26)

There is a realization that elected boards tend to be stakeholder or issue driven and wanting to be sure that (a) perhaps the government agenda was followed through but (b) making sure that you put in a group of individuals that saw themselves being more broader than just issue driven. (27)

We've had discussions within the system and within government and then back and forth as to one versus the other. I guess - and I would be one of them - the majority of people support appointment versus election because we're always sort of fearful of interest groups being organized, and I think we were looking across the country and I remember around the abortion issue when that became a heated issue - what happened out in BC and, you know, people got in and took over the agenda of the boards and so on. So I think it's... it was mainly to make sure that you prevent that, and you also get a region even in our case now, that you have an opportunity for regional representation and diversity in the board members. (28)

What of the fact that regionalization is the only major health reform that has been adopted in Newfoundland and Labrador? As part of another project, we studied six health care reforms in Newfoundland and Labrador: wait list management; private, for-profit delivery of health care; prescription drug reform; regionalization of health care; alternate physician payment models and primary health care reform and needs-based budgeting for health care. Of these, only regionalization has been established in the province. This led us to wonder if there was something unique about this policy that led decision-makers to adopt it as a way of managing change in the health system during the 1990s. Our participants share their thoughts on this issue.

The reason was because it was structural, the ordinary person didn't appreciate what it would mean, and the ordinary health care giver didn't appreciate what it would

mean. Well, that was one factor. The second factor is that the people who normally would've been the ones who would've made the noise had made a decision - and I'm talking about, for example, the Sisters [of Mercy], the Salvation Army, the doctors - they, for different reasons, realize something pretty significant had to happen and as long as it was controlled enough that their interests could be served, they were willing to recognize that this was harsh; but given the reality of the time, it was absolutely essential. So, normally, when you have a major public policy issue, it becomes a public issue with public resistance only if you have champions in the public against it. (3)

Regionalization was on the agenda anyway for fiscal reasons and a sense of this is the direction the country is going; we should jump on the bandwagon and, I mean, I also have my own theories - is that regionalization is, in fact, a way of gaining greater control, greater central control. You have less bodies to manage. If you have less bodies to keep an eye on, you can control them tighter; and I think, even if you look at the geographic structure as having virtually, I mean, two-thirds of everything in one structure makes it much easier to manage the budget. And I don't really think it's a devolution. I mean, if you're regionalizing, you're taking decision-making from the smaller communities and centralizing it, as opposed to devolving that because all of these boards had decision-making power and the boards had controls, and now you've got that down to just four boards. (14)

No, the champions that I remember were primarily government individuals who were champions of the cause. I do remember certain individuals in the Faculty of Community Medicine, who were always advocates of, you know, regionalization who believed that it could make a difference. I wouldn't say publicly I knew that. I mean, you know, Roy West, Doreen Neville - I mean, people like that I remember. Even Ian Bowmer. I remember, you know, as being an advocate of regionalization; but I don't remember them being public advocates. (20)

Well, I still think it goes back to resources. I don't think there was a person, whether you happened to be in government or the system, who felt that the system could be sustained as it was, so status quo was not an option. And it was driven primarily by the lack of resources. (28)

I think the primary reason there wasn't resistance [to regionalization] is because the people who could've been the champions realized that something had to be done; and as long as we could control the agenda a little bit, which we were able to do, then we would see this as something that we needed to move with. I think it would've been different; we still would've had regionalization but it would have happened very differently had the Sisters and the Salvation Army made a decision to fight it as opposed to endorse it. (3)

We've had reform in the two biggest portfolios within the government sector: in

education and in health. That's where we've had reform; and, you know, it has come whether... I mean, obviously, in the education system, it's quite clear that communities are not happy with the reform, but it is politically as well as policy driven by senior officials - that we need this reform. Education makes more sense to people because we see the numbers of children actually going down in the province. So even though from a community perspective the loss of your school is truly a loss of identity to a community and there was a fair bit of backlash in early days that people can see, you can't have these schools with so few children in them. It doesn't make as much sense to people in health when you look at it from an outside perspective, but it is the same issue. You know, we've had huge out-migration. Our population until last year continued to decline, decline, decline. And it's the same kind of rationale - we can't afford these services with the population that we have, with the transfer payments that we're receiving, with the budget that we have and that fact that we're... we don't... you know, we're not getting the money from the oil - we're not getting all of those things. So, politically, and from a senior bureaucrat perspective, this was the only way to go, irrespective of what the people in the community actually believe should happen. (12)

We continue to change the structures but we're not dealing with the real problems. We're not dealing with truly what are we going to do about the cost of health care in the province - the fact that the waiting lists continued to grow and that we haven't been able to manage that in any way - because, as I said, really nothing has changed in terms of the amount of money that's gone into the health system because government picked up the federal dollars. So we've not really dealt with the problems, which are too many services for the number of people we have or, you know... or streamlining and saying this is the priority service, but this is not the priority service. Now we've done some of that by virtue of doing nothing, right? (12)

There are several other issues that participants noted with respect to the decision agenda. Clearly a core issue is the lack of fiscal resources to sustain the health system. There was a sense of crisis that permeated discussions about the health care system beginning in the early 1980s and culminating with the national recession of 1991-94 and the cod moratorium of 1992. Regionalization was viewed by senior bureaucrats, some health providers and politicians as a way of sustaining the system in the face of federal reductions in health spending, rising technological and pharmaceutical prices, increases in salaries and the challenges of geography. An interesting perspective to emerge concerns the ability of the province to deliver the basket of core health services to the population given its limited fiscal capacity. One participant articulately addressed this issue:

The changes in fiscal federalism and, interestingly enough, in the 1990's the provincial government shored up the health system in a way that a lot of other provinces didn't. As they lost the dollars from the federal government, the government took money from the provincial caucus and put it into health at the

expense of education, income support, even roads and everything else - to shore up health so that there wasn't a lot of money lost to the health system. But we, in fact, didn't cut health services in the way that the provinces did. So from a political perspective, although regionalization was supposed to be about cost efficiencies, because health is such a huge political issue in this province and such a huge public issue is that the health services themselves weren't significantly impacted. You know, the actual day-to-day nurses and physicians and everybody else providing the service continued to be available. What we didn't keep up with were the new things like the technology - you know, the number of MRI's you're supposed to have per province. Those things we weren't able to keep up with but, you know, the numbers of hospitals and the numbers of services and the number of people working in the health system hasn't significantly changed. (12)

Other concerns expressed by participants include government's recognition of the determinants of health model by separating the institutional boards from the community health providers; regionalization is seen as a way for government to off-load services and difficult political decisions to the boards in order to avoid blame; the process of regionalization has not been well thought out because government simply embraced the concept in order to save money; the geographic boundaries drawn up for the boards were poorly thought out and pitted communities against each other; members of the health policy community have been reluctant and resistant to embrace social scientific theories and frameworks to ground restructuring and regionalization (i.e., community based approaches linked to economic development a` la Doug House); regionalization was adopted because of the influence of reports and commissions especially from the federal government and government championed regionalization because it would create a more client centred and efficient health system.

PART EIGHT REGIONAL HEALTH CARE: POLICY CHOICE

Policy choice focuses on what government adopted with respect to regionalization of health care. We will highlight three themes here. First, we will enumerate the goals of regionalization government sought to achieve during the 1990s. Next, we will look at which individuals and groups were excluded from the policy process and finally we will offer some views as to how the most current round of regionalization reform (since September, 2004) compares to that from the 1990s.

Participants were generally consistent in identifying the goals that government was seeking to achieve by adopting a policy of regionalizing health care delivery in Newfoundland and Labrador. Goals identified included saving money; making the health system more efficient; reducing duplication of health services; better patient care and the like.

You know, they [government] will tell you differently, but there was absolutely no doubt they were trying to slow down the increase in costs of health care. (3)

I truly believe reform... the genesis of reform was Treasury Board's budgets. When the money stopped flowing in the amounts that were normal, budgets started getting

cut because, don't forget Treasury Board gives a cheque to the departments. The Department [of Health and Community Services] then says, of its agencies and all its boards, how much each gets. And, I mean, I was back there in those days when all the cuts were there and I remember there was 209 people at the Department of Health before reform and 105 two years later. Lots of slashing. So that was Clyde Wells' days. No doubt in my mind, it was a budget process and it was financial and we got to come up with a solution and how can we save our political lives by doing this. (7)

Economics and efficiencies. So, you know, I do believe that there genuinely is the sense that we can create better efficiencies in the province. Now whether we can save money - you know, in my 24 years of working the... in the social and health sector, we've never saved money. There is no money ever to be saved because the system keeps developing and growing and technology and drugs and everything increases along with human resources costs; but if you don't save money, but you create efficiencies and even if you have a little bit of money that you use then to do something that creates another efficiency somewhere else, we're still overall improving how we provide a service. So I think there are those who believe we are truly going to save a lot of money. And we're going to save some money on the front end because we're going to decrease our administrative structure. However, we've learned in the past, as you decrease administrative structure, you decrease efficiencies in another way. (12)

Reduction in competition for scarce resources, elimination of any potential duplication and the continuity of patient care. (13)

There's more fiscal control. It's a more collaborative approach to health and more effective delivery of services. (14)

I think they [government] were looking to achieve economies. They were looking to achieve... they were sharing out resources. They were looking to achieve... I think, to some extent, centralizing control from their perspective so they had fewer more manageable units to deal with. Possibly looking to isolate some of the influences that were over these facilities which in some cases were church run - these sorts of things. (15)

Well, I think better services delivery, more coordinated service delivery, better use of resources, more efficient service. I mean if you've got two or three entities in the same general area and they're all separate boards and they're all separate entities, then your ability to deliver a service is... well, one could argue that your ability to service is better in a regional structure than an individual board structure, and your ability to move resources around from one to the other based on x and y - you know, designation, say, nursing staff in one area - you can redirect them around in a sort of fairly close proximity temporarily until that need that there's competing in capital or

funding priorities or a better decision at the end of the day is a regional board that's presenting the case. (19)

More coordinated health care, cheaper health care, higher degree of client satisfaction, a perception of a decentralized system one step away from government. So if the shit hit the fan, it wouldn't hit the government fan. (20)

Cost effectiveness. Well, I don't think that was the main driver. I don't think, in particular, this one is. I think that those of us who work in policy hope that it's for the bigger reason of providing better and efficient health services to the entire population and we hope that it is a gain for our health status. (22)

Efficiency and effect, and I think improved effectiveness. I think everybody really believed that we couldn't continue with, you know, little cottage hospitals and services everywhere - that we needed to consolidate to do better. I think that was a reason and the money - look at a better way of deploying our resources. (23)

There was a number of issues there. A lot of things that were said to government was that we think this will avoid duplication and lead to more cooperation in the system; but doing that, you might be... get better services in these regional centres than you would if you had competing... organizations competing for limited dollars and this type of thing. I think government saw that agenda, but I suspect they saw that there would be cost savings or at least relative cost savings in what the system might cost if you continued the way it was going versus bringing them together, and they were looking for, I think, some cost savings in administration, cost savings in support areas and trying to protect as much of hands-on delivery services as they could. Now I think that's what their agenda was. (24)

Well, save money - that was their goals. I'll tell you what they told us: save money, I think, was the number one priority; to be as efficient as they can. I believe that they believe that. I'm not sure that they weren't... it's centralization of services in large centres and I'm not sure they weren't setting us up for the next round because they've centralized even more now with the four health authorities. I'm not sure that they weren't sending a message to rural Newfoundland and Labrador around what type of services they're going to have to get used to in the future because of our geography and economics and the way our population is dispersed, and also what services people can expect to get where and how far away they're going to be from services. I mean, you know, so it's almost like they did one initial stage, and I think they were setting us up for this stage, and that's very cynical of me but... (26)

The policy choice agenda is limited to a select number of participants; namely senior bureaucrats, politicians, health care professionals and their member organizations. Ordinary citizens, labour unions, community groups and women's groups were excluded from the agenda. The shape of regionalization was dictated to the public from the top down to the ground. Among

our participants, the consensus was that government wanted to control the agenda and limited debate to as small a number of groups as possible and it respected the privileged position of physicians within the health system.

There are a lot of people out there in the community who've had very little voice and I think are quite concerned about this next level of integration into regional health authorities, particularly for the most vulnerable groups in society - you know, the children that are in need of protection, the persons with disabilities that are trying to live in the community and not be institutionalized - those with the least amount of money, those in poverty. I do believe that people are quite concerned that this group of people are going to lost, but you're not hearing much from them.

And I think that's because there is no avenue for them to have a voice. And I think that's one of the things politically, that's different with this new government [Williams] than with the old government [Tobin-Tulk-Grimes]. With the Liberals in the last few years of their reign, they were out there asking the people what they thought. Now whether they then implemented that was a different thing, but they actually asked people. There were opportunities; well, we're going to have a consultation on this. We're going to have a consultation on that. I mean, their Strategic Social Plan - the whole process of consultation around the Strategic Social Plan and then establishing an advisory committee to the premier on that issue. You know, there was a huge consultation process around all of the health issues. There was an economic consultation process. What this government [Williams] has done is kind of say, you know, okay, well maybe we have all the information. I don't know if that's what they're saying but they're not out there consulting and they're not providing avenues for consultation. So... and they're not particularly interested, it appears to me, in what people have to say. So the most vulnerable groups don't seem to have a voice and don't seem to be able to find an avenue to have their voice heard.

(12)

Well, unions were certainly excluded and I think, for the most part, professional associations. The Allied Health groups, I think they're even less included sometimes than we are because they're so diverse and whatever, but, you know, we were brought in when it was done. We weren't brought in when it was... once the decisions were done, we were told these are the decisions and these are the possible impacts and then we were into putting out fires as to what impact that will have on our membership and, you know, negotiating transition agreements to look after job losses and layoffs and get job competitions. I mean, all our efforts were on trying to mitigate the fall-out versus input into how is it going to structured, right, I mean, and we had a lot of confrontations. There were a few confrontations with the new health boards as to how seniority will be handled. (26)

The public, generally, and I guess at that stage we all evolved from the traditional system of 'we know what's best for you'. Okay? (28)

Comparing the two most recent rounds of regionalization is problematic because the current round has not completely evolved and developed at this point in time (May, 2005). However, one key difference that has emerged is the lack of consultation by the Williams government on reducing the number of regional health boards from 14 to four new integrated authorities. As noted above, the Progressive Conservative government seems determined to cut costs where possible and there is speculation that the latest reduction in the number of boards is driven solely by fiscal considerations rather than those geared toward improving the health system or patient care.

This round of regionalization is strictly driven through government through the appointment of CEOs who really didn't know what was on the go so it didn't come from that. It was, again, a reaction to trying to get the glove to fit the hand, so to speak, with respect to the economies and the government. I think government felt that there were savings to be made by bringing it [the number of health boards] down to four. This is strictly an efficiency for delivering services. But, no, this was driven by government. I think everyone was in the dark and they still are in the dark at the board level. (7)

We've gone now to the largest level of integration. We have done it. You know, I mean we've got work to do. We're only starting it which, of course, means we have busy work for the next two years. Now in that two years, there have to be some decisions made around the big ticket items. Are we going to close some hospitals? Are we going to take the services out? Are we going to move our physicians around so that they're happier where they are and you may get some level of primary health care, but you're not going to get anything secondary in your area and you're going to have to travel to Clarendville or St. John's to get it? But now is the critical time and I think the time is critical because this Premier [Danny Williams] he's only one year into his mandate and he's quite clearly said, from his perspective I have no interest in whether I get re-elected. So he comes with a very different agenda than most politicians. Now I don't believe that all of the politicians that are in his party necessarily feel the same way. (12)

There was no consultation in this round and there were no opportunities offered for input or comment, even in terms of once we've made the decision that this is going to happen, there was very little input into how it's going to happen or what it will look like. Essentially, the only people involved in that were the existing senior administrators: the CEOs and the existing organizations. There was no consultation with the communities. Again, I think I speak particularly to the Eastern region where the rural communities were quite disturbed by the decision to integrate the geography of the existing eastern and St. John's area. When the first regionalization happened, there was very limited service in the way of home care and home supports, and that kind of a program evolved through the evolution of the old health and community services structures; the board structures that happened in the 90's,

and so the demand for those services increased; and so, in terms of the economics of the health care sector, there may have been more pressures in the system that exists now as opposed to then. (14)

Well, frankly, the vision hasn't really been articulated to people this time, aside from having the regional structure; and I think the big difference is that there's no articulation of it. There's been simply a decision; someone decided to do it and we're going to do it now and we're going to do it this way. (14)

I think some of the forces like budgets, primary health care, coordination across sectors those types of things - they're definitely the forces.

There were... the consultation occurred back in 2001, but the decision was made last year [2004] in the budget and budget speech. So the decision was made and I guess consultation occurred maybe before that or after that, but I don't... there wasn't a widespread consultation on that, no. (25)

I don't think I'm as afraid of it [regionalization] as I was in the 90's; and, you know, regionalization... this regionalization, I've said, could be a good thing. It depends on whether the new health authorities are given enough money to do what they need to do and if there's good leadership. And we haven't seen... we didn't see many cases of good leadership in the health boards set-up in the 90's, and I think that's why we ran into a lot of problems from our perspective - and on all levels of leadership. I'm not just talking about top leadership. And there might opportunities here to learn from some of those mistakes. But in terms of government decision-making, they made the decision around what their lines were. They never included us in anything. They called us into a briefing and told us. And I said, oh! - Grenfell is with Labrador - gee, never thought that. So, I mean, we had no input into that process. Now the Liberals did do a consultation back 2001 maybe - on, you know, where we need to go about provisions of services and service delivery. So we were expecting with them to come... and it was in their health plan - provincial health plan - that they were going to look at that and primary health care was a big piece of that, and we need to look at provisions of services. So I guess we knew that another round of regionalization was coming but, essentially, government made the decision on the boundaries and whatever. There was very little consultation with us anyway. (26)

One of our fears about having these integrated authorities is that community health will be lost because acute care sucks the life out of them, right, and we can't function like that anymore, especially with the downloading to communities. On the converse side of that, now that these health authorities are integrated so that they are responsible for, you know, pre-admission care, acute care and public health, they can't now send the patient out the door and say, oops, you know, got a bed now I can fill and they're no longer my responsibility. When the client goes home, they are still the responsibility of that health authority so they have to make sure services are

there, and I think there could be an opportunity to hold them more accountable and that could be a positive thing, if the funding is there to have the community resources; but I don't think there can be the passing of the buck to the patient like there was in the 90's, which is what we saw, right. (26)

PART NINE CONCLUSION

The evolution of regionalizing health care delivery in Newfoundland and Labrador is an ongoing process. Since the creation of the first institutional health board in 1994, the province has witnessed two major phases of reform designed to curb health spending while maximizing patient care and service delivery. The struggle to provide sufficient funds for burgeoning health care demand is not unique to our province. In one respect, an argument can be made that the reform of the health system in terms of regionalization has been innovative in that service delivery has been maintained and the system has not collapse. However, the demand for money has drained resources from other portfolios, especially education. Two conclusions can be drawn from the lessons of regionalization in Newfoundland and Labrador. First, reform was undertaken because of a fiscal crisis caused by recession, the collapse of the northern cod fishery and reductions in health care transfers to the province from Ottawa. Second, the institutional or acute care providers were separated from the community or public health providers in the 1990s because the government finally recognized that health care prevention and promotion is money well spent. Getting your citizens to eat more healthy, exercise, quit smoking and lose weight means lower health care costs down the road. The dilemma, unfortunately, is that politicians operate on a four year cycle and long-term reforms do not have immediate political payoffs. As well, when reforms are announced, politicians and senior bureaucrats often cherry pick those recommendations that are the least harmful to implement. Much work needs to be done to follow the evolution of regionalized health care. This paper represents the first step on that journey.

APPENDIX A: BOARD CHAIRS, CEOs AND MEMBERS 2005

On September 10, 2004, the provincial government announced that the 14 institution and community services boards would be reduced to four integrated health authorities. The new boards, with the Chairs, CEOs and members are listed below.

Eastern Regional Integrated Health Authority

Chair: Joan Dawe (St. John's)

Members:

Sister Charlotte Fitzpatrick (St. John's)

Primrose Bishop (St. John's)

William Boyd (Mt. Pearl)

Ed Drover (St. John's)

Dr. Alice Collins (St. John's)

Frank Davis (St. John's)

Barbara Roebothan (St. John's)

Hubert McGrath (Patrick's Cove)

Lewis Cole (Carbonear)

Rowena Bryans (Clarenville)

Dave Duffett (Catalina)

Marjorie Gibbons (Forest Field, St. Mary's Bay)

Ed Walsh (Marystown)

Doreen Jackman (Grand Bank)

David Hiscock (Brigus)

Regina Bailey (Shoal Harbour)

Paul Colbert (Gull Island)

CEO: George Tilley

Central Regional Integrated Health Authority

Chair: Robert Woolfrey (Lewisporte)

Bill Broderick (Baie Verte)

Fred Ivany (Gander)

Jeanne Dillon (Gander)

Cyril Farrell (Grand Falls-Windsor)

Kevin Manuel (Lewisporte)

Joan Barbour-Howse (Wesleyville)

Rita Sullivan (Grand Falls-Windsor)

Betsy Saunders (Glovertown)

Daphne Woolridge (Grand Falls-Windsor)

Barbara Butt (Springdale)

Elizabeth Barlow (St. Alban's)

Gerri Poirier (Twillingate)

Kerry Noble (Gander)

Paula Mills (Bishop's Falls)

CEO: Larry Diamond

Western Regional Integrated Health Authority

Chair: Anthony Genge (Corner Brook)

Madonna Hynes (Codroy Valley)

Regina Warren (Corner Brook)

Charles Pender (Corner Brook)

Minnie Vallis (Meadows)

David Kennedy (Port Saunders)

Tina Moores (Stephenville)

Dianne Hewitt (Port aux Basques)

Evelyn Organ (Deer Lake)

Don Fudge (Rocky Harbour)

Wayne Pye (Trout River)

John Manuel (Corner Brook)

Susan Fowlow (Stephenville)

Tom O'Brien (Stephenville)

Sheila Mercer (Deer Lake)

CEO: Susan Gillam

Labrador-Grenfell Regional Integrated Health Authority

Chair: Larry Bradley (Happy Valley-Goose Bay)

Katie Riche (Natuashish)

Rev. Jean Brenton-Hickman (St. Anthony)

Lisa Dempster (L'Anse-au-Loup)

Eric Belbin (Labrador City)

Garry Furlong (Flower's Cove)

Judy Way (Happy Valley-Goose Bay)

Mary Abbass (Roddickton)

Ray Norman (Wabush)

Nick McGrath (Hopedale)

Garfield Flowers (Sheshatshiu)

Anastasia Qupee (Happy Valley-Goose Bay)

Mary White (Labrador City)

Debbie Singleton (Nain)

Janice Barnes (Charlottetown)

CEO: Boyd Rowe

APPENDIX B: LIST OF RESPONDENTS

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APPENDIX C: MAPS OF REGIONAL HEALTH BOARDS

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^a . The number in parentheses following each quotation refers to individual participants in our project. See appendix 2 for sketches of the participants.