

**Comparative Provincial Health Reform
Regionalization in Saskatchewan
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Over the past decade and a half, most provinces in Canada have undertaken a form of regionalization of their health systems. Ontario remains an exception to this, and it is increasingly clear that the recent formation of Local Integrated Health Networks (LIHNs) in that province are, despite some similarities, are not going to operate in the way that regional health authorities currently do in other provinces. It is also worth noting that Prince Edward Island is moving away from its regionalized structure having concluded that regionalization in a province of less than 150,000 residents is unnecessary.

There appears to be two basic models of regionalization in the country. The first, and most common, is one that collapses the governance structures for health care institutions across a geographic area and replaces the myriad of governing boards with a single governance board for the region. This basic model is found in the four western provinces and three of the Atlantic provinces. The second, illustrated by Quebec and to a lesser extent the recent changes in Ontario, creates regional governance structures designed to coordinate service delivery across a geographic space but does not remove boards governing individual facilities. In this second model the regional authority can have significant authority to direct institutions (as in Quebec) or relatively little authority as appears to be the model emerging in Ontario.

The concern here is with the reorganization that took place in the province of Saskatchewan in the early 1990s which saw the creation of 32 or 33¹ health districts

¹ The lack of clarity over the numbers of health districts relates to the fact that the district created in the far north of the province was not a health district like the other health districts in that it involved participation

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

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

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

of local Aboriginal governments (in the form of Tribal Councils) and had significant federal involvement because of that government's constitutional responsibility for services to on-reserve Aboriginal populations. A similar arrangement exists today with the newly created Regional Health Authorities.

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

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

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

“community health centers.” Many people saw these conversions as the *closure* of their community hospital. These changes tainted the reform efforts already underway so that health reform suddenly became synonymous with hospital closures. Primary care reform was effectively stalled, although it never fell off the government’s purported agenda and the current improvement in the financial situation of the provinces has allowed some progress in recent years.

This paper discusses the regionalization reforms in the province and attempts to understand *why* such efforts were undertaken and the policy process surrounding the decision. To help flesh out the literature currently available, 13 interviews were conducted with members of various sides of the regionalization debate. Members of the civil service, elected officials, the Saskatchewan Association of Healthcare Organizations (SAHO: previously known as the Saskatchewan Healthcare Association (SHA))², community clinics, health regions, academia, and the Saskatchewan Union of Nurses (SUN) were interviewed in order to obtain a broad array of interpretations.

What Happened (definition of the issue)

The move in Saskatchewan to 33 Health Districts from over 400 independent boards in 1992 was one of the largest-scale health reforms since the inception of medicare in 1962. “The early thinking was that there were going to be many levels of reform which was about the high cost of the sickness system. One of the elements of reform was governance. There were all kinds of blockages in the system at the time due to the sheer number of boards. When a patient needed to switch from one board’s

² The SAHO is a tiered membership association, the governing members are the regional health authority boards, followed by the affiliate members made up of the hospitals and special care homes affiliated with the regional authorities, the next two tiers of allied and associate members are the not-for-profit direct care providers and finally the not-for-profit health related agencies which do not provide direct patient care.

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

Having this multitude of boards working within their own stovepipes created a duplication of many services.⁶ Many participants in this study pointed to coordination of services as a driving factor for health reform. For example: “we had a lot of independent little fiefdoms...where there wasn’t a lot of co-operation even between facilities in the same town or city and they didn’t work together to look at it from a client perspective, how do we provide the best, or at least the perception was that they didn’t look at it from a client perspective and try and move then through various pieces of the spectrum...in any kind of co-ordinated fashion.”⁷ Integration and coordination of services in the health system was therefore an important facet of reform. In the Saskatchewan Government’s *Planning Guide for Saskatchewan Health Districts*, one of the key reasons for the

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

In 1990, the Commission on Future Directions in Health Care, known as the Murray Commission, proposed a structural change for the health system to deal with this fragmentation. The Commission was created by the government of Grant Devine at a time when health care costs had reached thirty per cent of government program expenditures. As a result cuts in programs were already being instituted; the Children’s Dental Program was eliminated and cuts were made to the Saskatchewan Drug Plan. The Murray Commission was tasked with examining how health care was organized, delivered and to make reform recommendations. Most of the participants in this study recognized the importance of the Murray Commission in the regionalization of health services. It is important to note that the Murray Commission submitted its report under a Progressive Conservative government while at least a portion of its recommendations were implemented under a New Democratic government. Therefore, the opposition party could not oppose the regionalization initiatives as they had been the first to recommend such a change.⁹

However, while the Murray Commission set the ball rolling in terms of the idea of health districts, the newly elected NDP repackaged the concept with a very personalized stamp. “The seeds were sown through the Murray Commission but the NDP when it came into power after the PC government, put its own mark on it and then very assertively implemented the district model. And I don’t think we have ever seen a situation where, for instance the Minister of Health was so involved in marketing its

⁸ Saskatchewan Health, *Planning Guide for Saskatchewan Health Districts*, 1994, p.1-2.

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major structural change in a health care system. Like Louise Simard went to just about every community in the province marketing the move of the district construct.”¹⁰

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

The essential difference between the Murray regionalization and the NDP regionalization is the emphasis on the driving vision - the concept of wellness – that the NDP used to contextualize the process: “The wellness approach offers a vision for health that is characterized by an enhanced quality of life, an increased span of life with good mental, physical and spiritual health, significant reductions in preventable death, disability and illness, and greatly reduced disparities in the health status of population groups within Saskatchewan. Wellness is not only about the prevention of illness, it is also the treatment and management of health conditions and life events. Coping with

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

In addition, there was an attempt to filter money out of hospitals and into more primary care settings to de-emphasize acute care. “We knew all the money was in the institutional sector and if we intended to get any help whatever, any money whatever to begin to start a new wellness program we had to get it out of the institutional sector. At that point without knowing we had such a crisis in finance we knew we didn’t have...new money. So I mean it was an easy guess to say well we’re going to have to take control of the health sector.”¹³

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

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

¹² Saskatchewan Health 1993, p.3

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Health Districts (Parts I and II). These documents were the result of a task force on wellness, something that participants affectionately referred to a “skunk works.” “We set up this task force on wellness which we put off into the, we called it the skunk works. You probably didn’t know that word. The skunk works, that’s what Louise called it. And the people we put into the skunk works were taking it out of the normal business of government and putting it, we borrowed space at the rehab center I think and put these people in there to give us some of the up-to-date thinking from around the world in what wellness and health should look like...And we have them I think about ninety days to frame this thing and what they came out with amazingly was not an organizational design but a series of programmatic statements or emphasis which in fact said here’s where you get you...here is the kind of thing that you need to do to get emphasis on the health and (out) of the buildings and (off) of the sickness”.¹⁶

In the *Vision* document, the role of the newly created health districts within the health system was defined as follows:

- Conduct health needs assessments and develop district health plans.
- Integrate and Coordinate health services within the district. This will include establishing arrangements to safeguard the rights and missions of privately-owned health facilities.
- Manage all health services within the district.
- Develop community health centres. These centres may take a variety of forms to be determined by the district, such as ‘health

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and social centres,' co-operative health centres,' 'community clinics' or 'wellness centres.'

- Ensure that all health services within the district meet specific provincial guidelines and standards.
- Be governed by a single health board.¹⁷

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

The information campaign, including all of the public documents and public meetings, was described by an elected official as “a whole cadre of people who actually went out and sold it to the public...this was done to get communities to understand what was behind health reform”.¹⁸ “There was a whole crew at the Ministry of Health that pushed the agenda and sold it out on the hustings. And they need to be recognized in any sort of history that’s done because there were public servants out there taking flak...a lot of very difficult situations. They bared the brunt of the criticism. It was an incredible amount of work. They went into a very, very difficult situation and stood up for the government policy.”¹⁹ Not only were politicians able to avoid difficult situations especially after the hospital closures but the local citizenry were able to discuss the issues with knowledgeable bureaucrats.

¹⁷ Saskatchewan Health, *A Saskatchewan Vision for Health: a Framework for Change, A Guide to Core Service for Saskatchewan Health Districts*, 1992, p.17.

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Generalizing from participant responses of those who were a part of the civil service at this time, government wanted the public to understand the reasons behind health reform. And Saskatchewan's citizenry was particularly accepting of health reform as it was packaged prior to the facility closures. One participant in the civil service recalls a conversation with the Health Minister of British Columbia around this time in which she remarked: "you folks have one thing going for you that we don't and I envy you for it...the fact that people in Saskatchewan know that you're in desperate financial situation and seem prepared to, you know, make some sacrifices if that had to be done. She said out...in B.C. nobody believes that we're financially strapped. And they were."²⁰

One important characteristic of the health reform process that may have contributed to the willingness of the public was the community development process used. While government devised the vision and the plan, communities were asked for their input to the extent that they were able to create their own health districts. "There was a very massive communication effort. And just involving, we had thirty-three stakeholder groups before we moved to the regions. We had these planning groups. We called on community leaders, we called on people from the communities and they came and sat on our planning groups. We had a meeting with them throughout the province. They were to do an assessment of necessary services and think in terms of what boundaries might be appropriate for them. And that in itself is a communication strategy."²¹ "We turned to the public at large and said throughout Saskatchewan you help us and yourselves plan the new health system. We will give you support ... we will give you workers if you ask for them or planners if you ask for them. We'll give you time and

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space and then money as you need it. But you get a group of health services gathered together and tell us what you want by the way of districts, programs, what are your requirements and what even the board will look like. And eventually we used the same group to tell us what the size and the shape of the district will be before we incorporated it.”²² By including the communities in this process a certain amount of public resistance was offset as half of the members on the health boards making these decisions were appointed from the local communities involved.

The initial planning for the district came out of these various health planning committees. It was recognized by the department that these health planning committees, largely made up of volunteers, may not have the capacity for all of the planning initiatives. Thus, the department gave assistance and support through all stages of the process. “These planning committees, in consultation with consumers and providers of health services and community leaders, as well as with the Department of Health, were asked to identify and gain the support of the communities to be involved in their respective districts in order to propose boundaries for the health district, recommend the processes and strategies for the establishment of an Interim Board, identify issues that should be addressed by the health district board, and begin the process of a health needs assessment in the district.”²³

Another possible reason for the initial success of the reform initiatives could have been the willingness on the part of stakeholders to participate: “we worked really, really hard to try to get everybody into the tent and so we met with the unions, and we met with

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²³ Duane Adams. “The White and the Black Horse Race: Saskatchewan Health Reform in the 1990s”, *Saskatchewan Politics: Into the Twenty-First Century*. Ed. Howard Leeson, Canadian Plains Research Center. University of Regina, 2001. p. 288.

the nurses, and we met with the doctors, and we met with the hospitals, and we met with the nursing homes. And they, you know, we know that they were never all going to agree on some of the things but at least they couldn't say we didn't talk to them".²⁴ The real support from the front lines came from the health leadership. Because of their position of being able to see the larger picture enabled the health leadership to recognize the need for some kind of reform: "you may have the leadership of physicians, the leadership of the Saskatchewan Health-Care Association at the time, the leadership of the ...special care homes. It was more at that level that you saw some of that coming out...so it wasn't from the nurse in the hospital or the doctor in the hospital".²⁵ The initial support was present surrounding the general idea of health care reform but once specifics were announced divisions occurred.

Physicians in the province played a very interesting role in the reform efforts. One participant described physicians as really staying outside of the process: not expecting government to actually go through with such large-scale reforms, any reforms were expected to be smaller in scope and scale. It was not until after the reforms were introduced that physicians weighed in on the changes, at which time they were displeased. Any initial support for reform quickly evaporated once the type and extent of reform was unveiled, the hostility to the reforms from the physicians truly began after the announced hospital closings. "Physicians were incensed at the regionalization and were trying to respond by setting up the, the SMA set up local committees for each district. And they were trying to get those...they almost treated them like union locals...had to

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get them going and they were still opposed to the regionalization and were trying to fight that almost in a post hoc manner.”²⁶

Unions also were not enamoured with reform. Specifically, the Saskatchewan Union of Nurses (SUN, one of the most influential health practitioner organizations in the province) believed that the strategy would result in mass layoffs of nurses. This was due in large part to the closure of 54 rural hospitals that had been providing twenty-four hour acute care, and their conversion into community health centers with an eight hour schedule. These conversions were to be done in conjunction with the primary care initiative as part of regionalization but the speed of the closures and the lack of initial direction and later with the delay of the primary care initiative led to concern amongst nurses. Nurses were to play a primary role in the primary care initiative including the creation of a new education program, the advanced clinical nurse. The class of 1993 – 94 had 35 graduates but within two years only two were operating under that classification.²⁷ SUN representatives much like the physician representatives initially supported the general ideas of regionalization but disagreed on the specifics.

While the community input strategy was largely successful, there were those who were worried about their place in a newly regionalized system. “Up to the point of the district model, health entities were developed under the leadership of local communities where you would have people who are passionate about having hospitals or long-term facilities, or home care programs and they came together as collections of citizens of communities or collections of communities to lobby the provincial government to get the resources they needed to engage in those kinds of activities. And the introduction of the

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district model was a radical departure from that.”²⁸ “We needed to make sure that the issue of ownership was not an issue. And it turns out only a very small number of very bright municipalities and municipal councilors understood that the wisest thing they could do was to off load those terrible old buildings onto the provincial government. Because and I might say that one of the...the nursing homes. The one that came to my mind mostly really was Pioneer Village in Regina...where the mayor and the city manager, Rob...reminded us about every month on that...because they had done their own cost...they needed something like twenty or thirty million dollars just to fix it up. But no, the government didn’t need that they wanted just to have control of the system as opposed to control of assets.”²⁹ This corresponds to a 1995 survey published in the Canadian Medical Association Journal; 76 per cent of the health board members who responded believed that the boards were legally responsible for things they did not have control of, and 63 per cent that they were too restricted by government regulation.³⁰ Through regulation the government was able to exert control over many operations of the health boards but could avoid direct responsibility.

Catholic hospitals were another interest that was mentioned in many of the key informant interviews. Catholic hospital boards argued that they would like to keep control of the hospitals so that they would be able to maintain the value system within them. “Some of the hospitals, not so little some of the urban hospitals too, because they either through religious groups or charitable things or whatever. You know, they brought together some money to start the hospital and get it going. And there was still this belief

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³⁰ Steven J. Lewis, et al. *Devolution to democratic health authorities in Saskatchewan: an interim report*. CMAJ • FEB. 6, 2001; 164 (3), p. 343.

that because of that it was their hospitals, like you know they owned it, they'd raised the money. Well I mean the fact that all the operating costs for every many years had been paid through tax dollars, had got forgotten. But, so there was that kind of parochial myth to it a bit. And that part wasn't an angry kind of thing, it was just the way they believed the world was."³¹ But in the end the regionalization initiative placed control with the health boards through affiliation agreements but ownership is maintained by the Saskatchewan Catholic Health Corporation.

Community clinics were similarly cautious about regionalization. As one participant affiliated with the community clinics observed: "the provincial government came to us and said they have an interest in transferring funding to community clinics to health districts. And we lobbied the government in resistance of that because we felt that ... the districts needed to be given comprehensive responsibility for primary health care delivery including the financial resources to support all primary health care delivery before the clinics will be transferred. Because our view at the time was that if clinics didn't have, or if the health district didn't have comprehensive responsibility for primary health care and primary health care resources if the community clinics were transferred to the districts that they wouldn't take ownership and value that. And there was some risk that they may...if they were financially strapped, re-allocate those resources out of primary health care and community clinics to support their more onerous mandates to long-term care or acute care, public health and home care".³²

The general feel of the debate around regionalization of health services was an understanding at least on an intellectual level of what the government was trying to

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achieve. No one was opposed to the vision and ideas surrounding health reform, but the concrete implications were what made various groups flinch. It is very difficult to argue with an idea that proposes better health for the provincial population. However, opposition to health reform arose when announcements were made that there would be conversions of fifty-two small hospitals into community health centers around the province. While government tried to rationalize the decision by explaining these hospitals were lacking the core competencies to deal with many emergent situations, it was too late.³³ Health reform and hospital “closures” had already been rolled into one entity in the public mind: the original plan was considered very progressive “and it’s when the hospital closure announcements were made that things turned because communities rose up against it, the press taking the community stand. And in a way making that announcement on hospital closures and the policy to move forward was very destructive to health reform because I believe that it caused ... much political fallout from it that government just lost the political will to move forward”.³⁴ So a discussion on regionalization would not be complete without a discussion of how hospital conversions changed the landscape for reform.

One participant affiliated with SAHO offered that their organization was one of the few that understood the move to “close” hospitals. Many of these hospitals were holding a more symbolic than functional meaning in some communities. Furthermore, these hospitals were being used for economic development; they largely employed wives, mothers and sisters of farmers whose income was propping up the farm income. Without delving into the contentious issue of farm incomes, when the hospitals were scheduled to

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be converted and thus many of the workers in these facilities would be laid off, there was opposition not *only* on the grounds of patient care, but on the grounds that these were incomes that were crucial in the community. According to our participant, this was not health care; this was economic development. And when the health system is being reformed to integrate and coordinate service delivery so as to reduce duplication, hospitals with an economic development function (rather than a health care function) were the ones to lose.³⁵

Another participant, a member of the civil service, reiterated that many of the converted hospitals served largely a symbolic function. Members of the communities in which there were small hospitals would often pass by their own institution in favour of a larger one within a short driving distance.³⁶ The small hospitals that were converted were not being utilized by the communities they served.

Because these hospitals served a symbolic function, communities were not willing to give them up. This is evidenced by the fact that there was opposition to facility closures *within the government caucus*. “There was opposition to the closure of hospitals and there was adamant opposition to it amongst the government, within the caucus.”³⁷ MLAs were the ones who had to go to their constituencies and sell the government policies.³⁸ This was difficult, as they had to tell their constituents that a cornerstone institution of their town would be converted into a community health centre with reduced capacities for care. MLAs faced the difficulty of arguing symbolism with rationality; and

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

Analysis

In the final analysis, it is the interplay between ideas and interests that really drove this process. The driving vision and philosophy consisted of an emphasis on integration and coordination of services to avoid duplication and improve efficiencies. This vision may not have been enough alone to drive such large-scale changes. It was the combination of the driving vision and the actors behind it that came together at a critical point in history that made these changes happen and a fiscal situation which made reform immediately necessary.

The vision for change “was based primarily on the thought that ... there was a lot of duplication in the health care system. Remove the duplication, provide better services, fill in the gaps where needed, provide more appropriate services where needed because we were putting long-term care patients in hospitals for example” (05reg). And because the vision was supported by so many of the health organizations in the province, that there was no concerted opposition to the ideas behind the regionalization change until the process was well underway.

While health leadership was generally in favour of the vision for change, one of the participants stated that the reason the changes happened when and how they did was because of the interests involved in the Department of Health. For example, in one civil servant interview the role of the Minister was described: “we had at the time...a very strong Minister, probably one of the strongest in the government...She certainly had a very...clear head about what she wanted to do and what things she wanted to change. So

I mean that always helps is when you've got that...when you've got at the cabinet table a person who is committed to and understands it well and can sell it".³⁹ Another participant described the role of the senior civil service: "It was intense and it was Duane (Adams) who drove the timing. He had the view that there was the appetite now for change and if we waited any longer people would start to second guess. If they didn't move that fast, it wouldn't have happened. The timing was right, so it came from the government's will and Duane's drive."⁴⁰

Another factor which must be mentioned when analyzing these specific changes is the historical context. At the time of the changes, "we had a new government, that government had also been studying this behind the scenes for a couple of years by then and by shadowing the Murray Commission, by getting out and talking to people. And they also had a very healthy majority so that they were able to do a much more definitive, almost Draconian move and still give themselves four solid years to recover from whatever negative backlash there was".⁴¹ The Government decided the time was conducive to a reform program.

While in many analyses of the situation, the fiscal crisis and health reforms get rolled into one, it must be noted that they are separate. The health reform vision was created before there was explicit knowledge of how deep the province's economic problems ran. But it must be recognized that while the two situations are separate the economic crisis did have a profound affect on the nature of health reforms. Rural hospital closures and conversions were done congruent to regionalization and other

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

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

Conclusion

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

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