The Democratization of Public Institutions:

The Case Study of Health Care Regionalization in Saskatchewan

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ABSTRACT

In 1993, the province of Saskatchewan regionalized
its health care system to make the system more
efficient and more cost effective. The process of
regionalization meant the amalgamation of over 400
institutional boards into 32 district health boards.
This structural centralization of control, however, was
accompanied by the devolution of power to the local
level. While this may mean an off-loading of fiscal and
political responsibility to the local decision-makers,
the decentralization of power and control could also
provide opportunities for the democratization of
decision-making, whereby the local people could not
only choose their local representatives to the regional
health boards, but would have more of an opportunity to
participate in the decision-making itself. This
participation, if meaningful and realistic, may provide
insights into whether regionalization could represent a
site for the democratization of public institutions.
In order to investigate this possibility, the
members from two regional health boards in Saskatchewan
were interviewed. The interviews were supplemented with
information provided by HEALNet and the PECOS projects.
Structurally, regionalization sets the stage for
deliberative democratization. However, there are many
intrinsic problems that need to be further explored,
for instance, the issue of political legitimacy and a
lack of community interest in participation.

ACKNOWLEDGEMENTS

DEDICATION

I would like to dedicate this dissertation to my
beautiful son Kade Robert Ray Torgerson who was born
while I was working on this dissertation. You sure made
it interesting kid. I love you.

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INTRODUCTION

In 1993, the province of Saskatchewan reintroduced a program of regionalization within its health care system, partly in reaction to the current issue of fiscal constraints and partly in response to the notion of community based decision-making. The recent program of regionalization involved both a centralization of power and the devolution of decision-making. Indeed, over 400 institutional boards have been amalgamated into 32 regional health districts, displacing many local institutional board members. At the same time, however, responsibilities for the provision of health care services and the allocation of funding were devolved to the regional health boards. The question here, therefore, is whether or not the district health boards serve as the sites for the democratization of health care decision-making. The local structure may enhance the possibilities for participation in the determination of health care policy.

Indeed, the placement of the newly formed regional health boards has certain positive and negative consequences. On the one hand, the district health boards

are institutionally placed between the provincial

government and the local community members, a situation

that may allow for the development of a public forum. Here,

all the stakeholders in the decision-making process may

have the opportunity to have their concerns and interests

included in the debates over service provision and resource

allocation. Here, the direction of control emanates from

civil society. On the other hand, control may simply be

funneled from state to civil society, making the district

health boards no more than the mouthpiece for provincial

demands or indeed, private concerns (i.e. professional

groups, interest groups, lobby groups).

There is a distinct possibility for the

democratization of public policy, giving people who are

affected by public policy (i.e. welfare, education, health)

a measure of control over its development and

implementation. The issue of democratization in this

respect goes right to the question of modernity. Indeed, if

the new structure of health care vis-à-vis the district

health boards, facilitates democratization by giving local

people more control over the health care system through the

devolution of control, elective representation on local

health boards, and the institutionalization of community

participation, then the democratization of public policy is being realized on a small scale.

However, at the same time, certain constraints may hinder this realization. For instance, time, citizen apathy, and budget constraints placed on the district health boards by the provincial government may lead to the by-passing of the principle of democracy espoused by the reform mandate. The need for efficient decision-making, in this respect, certainly leads to a situation whereby the principle of community participation, for instance, becomes too cumbersome and unrealistic. Thus, the district health boards are placed in a situation whereby they must perform a balancing act between the principles of participation, representation, inclusion and responsiveness, and the bureaucratic drive towards centralized governance and an over reliance on expert opinion.

Specifically, the new district health boards could emerge as a public space for the active deliberation of community members. Indeed, within such spaces, people are able to articulate their versions of the truth which reflect their community standpoint (i.e. health care needs), rather than being the passive recipients of policy emanating from administrators and policy makers within the Saskatchewan Health department, and health care

professionals. It means being active rather than being
acted upon.

This may have important inferential consequences for
the structure of the community itself. At the heart of this
project is the issue of community sustainability and how
the vitality of the community comes from the ability of the
people to direct their own lives, including the development
and direction of public policy. Evidence from development
plans suggest that the most effective means of ensuring
community development is to have policy directive include
the voices of community members, rather than relying solely
on the directives of external actors[1]. This speaks directly
to the issue of community revitalization and sustainability
since policy initiatives require that all the people
affected by decision-making are included, a move that
strengthens the bonds within the community and provides a
commonality of interest.

1.1. Issue of Sustainability

The present study is part of an overall investigation
into the multi-dimensional components of sustainable
development in Southwestern Saskatchewan. The project -
termed the Prairie Ecosystem Study (PECOS) - sought to
determine the meaning of eco-system sustainability, and
moreover, how it could be realized. The broad based

objectives, therefore, of the PECOS project were to "…
evaluate the sustainability of the semi-arid prairie
ecosystem in terms of the health of the land and the well-
being of the people and their communities, and to explore
the prospects for a way of life that does not jeopardize
these"[2].

In 1990, the federal government developed the Canada
Green Plan, in order to investigate the interrelationships
between health, environment, and sustainability. One aspect
of this, the Eco-Research Program, funded 14 projects
throughout Canada to look at the various components (e.g.
economic, cultural) involved in the relationship between
development and the environment and to develop a knowledge
base on the relationship between the health of the
environment and the health of the people. PECOS, as one of
these projects, was set up at the University of
Saskatchewan and the University of Regina to look
specifically at the semi-arid region of southwestern
Saskatchewan. The PECOS project itself was conceptualized
through an interdisciplinary and community-based research
agenda. About 50 researchers and graduate students from
various colleges and disciplines were involved in the
project, the full title of which is the *Sustainability of*

the *Semi-Arid Prairie Ecosystem: Imperatives for Agriculture, Environment, and Rural Communities.*

Structurally, then, the PECOS project was divided into three groups which had sustainability as their starting point, but which took different (and interdisciplinary) directions. The first group investigated the health and well being of the area residents and community sustainability. The second group looked more specifically at the connections between human health and agricultural practices, including pesticides. The third group was more concerned with the "effects of agricultural practices on the natural environment"[3].

The present study then, as part of the first team of investigators, began as an investigation into the problem of community sustainability - or rather, what factors, structural or otherwise, contributed to the maintenance of the rural community. One possible factor is the incorporation of community needs into the development and execution of public policy. Indeed, the conclusion made here was that it was only through the transfer of power to the people and thus the ability of the people to become more involved in the determination of public policy, that community sustainability could be more readily realized.

The administrative part of the PECOS project was undertaken by the TriCouncil Secretariat on behalf of the federal government. The funding sources came from the Social Sciences and Humanities Research Council (SSHRC), the Natural Sciences and Engineering Research Council (NSERC), and the Medical Research Council (MRC).

1.2 Regionalization and Sustainability

Regionalization has important implications for Saskatchewan communities. Regionalization, for instance, could have certain ramifications for the viability of Saskatchewan communities, particularly at a time when the rural community in Saskatchewan is on the decline.

There have been certain connections made between community sustainability and the devolution of decision-making. Most of the literature on this paradigm shift comes from the developing nations and the transformation of the process of modernization to one based on reflective and interactive decision-making. Often, however, this has resulted in the co-optation of the culture and sociality of the local people. Yet, there is a growing consensus that empowerment and participation remain viable initiatives, as long as the spirit of their meaning remains close to the goals of local and personal autonomy and control.

Here, the key to genuine democratization means that all the parties with a stake in the outcome of policy should be at the centre of decision-making. This means that decisions should not be merely reflective of expert and bureaucratic domination, but rather, should be the end result of meaningful debate with the affected stakeholders. Furthermore, this involvement should be recognized at all levels of decision-making. It should also be proactive rather than being reactions to decisions that have already been made by external actors. As Schneider argues:

> Genuine participation means that the people should be involved throughout the project or program cycle, from the design stage through monitoring and evaluation. Mere consultation of the people should no longer be considered as sufficient, nor should participation be limited to the implementation of activities previously defined from outside[4].

Participation in the various stages of policy serves a range of general development objectives, such as "efficiency, equity, capacity building, and sustainability"[5].

Generally, transferring the power to the local level is argued to effect public policies that are adjusted to local needs. That is, local authorities are purported to have a better grasp of the needs of the community than the experts or the centralized state, and can make more

effective decisions. Indeed, the arguments for participation and community empowerment challenge the notion that control over policy should legitimately flow from the expert or techno-bureaucrat and exclude the very people it affects. Reliance on the top-down management of power can create conditions of passivity, coercion, and even resistance to development plans.

Empowering the local people and creating conditions for their participation in the decision-making thus has important implications for sustainable development. The involvement of communities in the decision-making, for instance, has been linked to building a self-reliant and sustainable community structure[6]. Indeed, sustainable communities are those that manage their own resources, and trust their own decisions[7]. Schneider, for instance, argues that: "Sustainability in particular depends on people being in charge"[8].

The key to sustainable development, then, is intrinsically related to the incorporation of traditional and personal forms of knowledge into the process of decision-making. This means, therefore, a reexamination of the dominance of professional expertise and its belief in the superiority of modern science[9]. Traditional structures of control, such as expert and bureaucratic imperatives,

are thus expanded to include previously disenfranchised

groups. The inclusion of non-professionals and community

members within the decision-making has been linked to the

viability of a sustainable development project. For

instance, Setty notes that:

> Change which is brought about by a sharing of an
> effort and social participation, possesses
> democratic vitality and is also realistic. Self-
> imposed changes have permanence as compared to
> those from outside and above[10].

A participatory project, therefore, implies the inclusion

of the disempowered in the decision-making, as well as a

certain respect for diversity and self-reliance[11]. If policy

initiatives follow this line of reasoning, they would be

structured around inclusion and democratic participation.

The concepts of empowerment and participatory democracy are

interrelated with sustainable development. However, the

actual development of an operational strategy of

empowerment and participation is more difficult to realize.

Empowerment and the will to participate, for instance, must

come from the people themselves, rather than being a value

accrued to them by experts. This means breaking apart the

relation of dependence on professional expertise and

bureaucratic paternalism, thus allowing people the space

first to value their own interpretations of reality and

then allowing them a voice in the decisions that directly

affect them. Policy changes can decentralize power to the local and individual level, and create the structural necessities for democratic participation. However, policy change cannot in-and-of-itself create the willingness of people to change the patterns of dependence upon experts and the state, nor can it compel people to participate. What it can do is create the conditions by which decision-making is democratized. One such strategy is to decentralize the decision-making; thereby ensuring that the decision-making is more accessible to the local population and thus more accurately represents their culture, social networks, and knowledge.

Therefore, it follows that the success of a sustainable development program depends on many complex variables, including the attitude that local people can make effective decisions, that they should be included in the decisions that affect them, and that decision-making should include, and be responsive to, all the stakeholders involved.

It is in this context that the possible impact of health reform on community sustainability can be presented. The reform is premised on the notion that the people of Saskatchewan should have an increased sense of ownership and control over health care. Both the fragmentation of the

boards and the top-down mode of governance detracted from a sense of community control and empowerment[12]. For example, the appointment, rather than the election, of hospital and home care board members only served to entrench the community's lack of control and enhance the confusion over their role[13].

The promise of regionalization is that it will enhance community control over health care decision-making. Explicit within the reform mandate is the principle of "increasing community involvement in the health system"[14]. The elected health board, for instance, becomes an institutional site for ensuring that community members have an important impact on what programs are offered in their local area and how they are funded. It means that the mode of governance becomes more bottom-up, as the community members are able to define their health needs and have the necessary services implemented.

The localization of decision-making does have important ramifications for community sustainability. Indeed, one important indicator for a self-reliant, cohesive, and viable community structure is the transference of power to the local level. In other words, a sustainable community is one that is able to control its destiny and adapt to change. A common direction will be

fostered and the people will feel that their opinions,

knowledge bases, and expertise count in policy initiatives.

This is not to say that regionalization will directly

translate into sustainability. However, it does provide a

very valuable clue about what factors, beyond economics,

are needed for a viable community structure.

These kinds of issues are timely. The sustainability

of rural communities in Saskatchewan is a pressing

concern[15]. There has been a steady exodus of young people,

particularly women, from rural areas to the urban centres

in order to find work and a better quality of life[16]. Added

to this is a decline in rural services. The closure of

hospitals, schools, stores, etc., has a crippling effect on

the cohesiveness of the community.

One example is the impact of hospital closures on the

economic and social viability of rural communities. In the

cases that have been documented, the closure of rural

hospitals has been connected to a decline in community

viability and sustainability[17]. This has certain

ramifications for Saskatchewan since due to the need to

reduce the duplication of services in order to control

costs, 52 rural hospitals have been closed since the reform

was enacted. The implications of this for community

sustainability, therefore, will require some further

examination. What is known is that most people (72% of those surveyed) consider the availability of a hospital important in determining where they live[18]. Moreover, a crisis of legitimacy arose at the time of the hospital closures since the rural people felt that they did not have a say in which hospitals would be close[19].

These kinds of concerns do inevitably arise at times of massive restructuring. At the time of the reform, rural people demonstrated against the reforms, mainly with fears that their services would be further eroded[20]. For instance, one concern that is found within the rural areas is the availability of physicians[21]. The fears over the viability of the rural community, therefore, were deeply rooted in the rural consciousness. Support for the reform, therefore, will be a mitigating factor in its ultimate success.

Thus, while there is a need and desirability for community participation in health, it cannot be implemented without the express consent of the citizenry. Without this consent, the discourse over the devolution of decision-making could merely provide the *appearance* that Saskatchewan people are being listened to, while the flow of decision-making continues in a "business as usual" manner. In this respect, the mechanisms for the democratization of health care service and delivery could

remain more as fodder for rhetoric rather than realistic policy.

1.3 Chapter Development

This dissertation is composed of five chapters. The first chapter provides the theoretical model for the democratization of decision-making. In the first section, the stage is set for the issue of democratization in modern society. Indeed, democratization is contextualized within the modern dynamics of globalization, and complexity. Next, the dominant paradigm of liberalism is first presented, along with a critique of its basic tenets. For instance, the notion of citizen alienation and the decentering of power within modern society are presented. The third section further develops the critique of liberalism through an analysis of the introduction of a public sphere and the need for a more affective forum for inclusive decision-making. It is at this point that the participatory model of democracy is briefly outlined. Finally, the possibility for the democratization of public institutions, as presented by Arato and Cohen, is presented. Here, the notion is that democratization cannot be truly realized without institutional change, which enhances public participation, is summarized.

In Chapter Three, the regionalization of health care is further developed as a case study for the democratization of public policy. The first section contextualizes health care regionalization within the current political economy of Canadian health care. Regionalization is presented as an instance of institutional change, which is geared towards ensuring the economic and structural sustainability of Medicare.

The second section describes the institutional changes involved within health care regionalization, particularly the devolution of authority to the local level, the possibilities for the election of health board members, and the potential inherent within regionalization for community participation. Section Two also begins a critical analysis of the potentials for regionalization, using past and present regional models as a point of reference.

Chapter Four begins with the research question: "Do the district health boards serve as the structural site for the democratization of health care services at the community level as perceived by the health board members?" The question is broken down into three structural themes explicit within the reform: devolution; the election of board members; and, the implementation of community participation.

The research units utilized are two regional health boards and the sample consists therefore of Saskatchewan board members. The data collection instruments include the documentation of provincial and board records, the use of secondary quantitative data, and an interview that is composed of both open-ended and closed questions. The data analysis is an inferential description of how the institutional changes have democratized Saskatchewan health care.

The open-ended questions were coded using the ETHNOGRAPH 4.0 computer program. The closed-ended questions and the data from the quantitative secondary sources are presented using simple frequency distributions. Also included in this chapter are questions on validity and ethics.

Chapter Five describes how regionalization is being realized in Saskatchewan. The first section contextualizes the data within Saskatchewan's unique institutionalization of regionalization. Here, the findings from the quantitative and qualitative data are presented using devolution, local elections, and participation as thematic guides.

The second section of chapter Five describes how devolution has changed the sites of control within health

care. The past structure of institutional boards is presented as a baseline for how control has shifted to the community members. Yet while control has been devolved, the board members argue that it is not absolute. Structurally, the provincial government does need to maintain an overall standard for health care provision. However, the board members report that the provincial government uses political tactics to direct board decision-making, thus eroding the boards' legitimacy with the local population.

The third section of chapter Five presents the information regarding the use of local elections. The general consensus here is that the reform did serve to enhance the representation and accountability of the decision-makers. Connections are made by the board members themselves between the use of local elections and an increased sense of representation and accountability to the local population.

In the fourth section, the regional board members describe the promises and problems of participation. Here, participation emerges as an almost unattainable ideal due to a lack of communication, citizen apathy, and an uncertainty about the actual role of the board in the community. The board members argue that they are inclusive, and that they do incorporate the expectations of the

community members into their decision-making. However, the

implementation of participation is somewhat superficial at

this stage.

Chapter Six presents a synthesis of the research

findings with the possibilities of democracy. The results,

therefore, are used to assess the usefulness of health care

regionalization in Saskatchewan as a case study of the

connections between institutional change and

democratization. It is concluded that regionalization

structurally provides for conditions of democratization.

There are, however, some issues related to its effective

implementation that need to be addressed.

NOTES

[1] H. Schneider (1995). *Participatory Development: From Advocacy to Action.* Paris: Organization for Economic Co-operation and Development.

[2] H. Dickinson (1998/1999). Sustainability and Health: The Prairie Ecosystem Study (PECOS). *Health and Canadian Society,* 5(2): 177-188.

[3] *Ibid,* p. 184.

[4] H. Schneider (1995). Concepts, Issues and Experiences for Building up Participation. In H. Schneider (ed). *Participatory Development: From Advocacy to Action.* Organization for Economic Co-operation and Development

[5] *Ibid:* p. 33.

[6] C. Bryant (1994). *Working Together Through Community Participation, Cooperation and Partnerships.* St.Eugene, Ont: Econotrends Limited.; T. Hancock (1996). Healthy, Sustainable Communities: Concept, Fledgling Practice and Implications for Governance. *Alternatives.* 22(2): 8-23; J. Robichaud and C. Quiviger (1991). *Active Communities: A Study of the Local Community Health and Social Service Centres in Canada in 1988.* Ottawa: Canadian Council on Social Developments.

[7] J. Friedman (1992). *Empowerment: The Politics of Alternative Development.* Blackwell: Cambridge.; N. Singh and V. Titi (date unknown). *Empowerment for Sustainable Development: Towards Operational Strategies.* Winnipeg: International Institute for Sustainable Development.

[8] Schneider (1995): p. 33.

[9] *Ibid.*

[10] E. Setty (1985). People's Participation in Rural Development: A Critical Analysis. *The Indian Journal of Social Work.* vol. XLVI: 73-83.

[11] P. Fong (1986). Citizen Participation and Administrative Decentralization in Hong Kong. *Habitat International.* 10(1/2): 207-217; Singh, and Titi (date unknown).

[12] Saskatchewan Commission on Directions for Health Care (1990). *Future Directions for Health Care in Saskatchewan.* Saskatchewan Department of Health.

[13] *Ibid.*

[14] Saskatchewan Health (1996). *Health Renewal is Working: Progress Report.*

[15] M. Gertler (1994). Rural Communities and the Challenge of Sustainability. In J. M. Bryden (ed).

Towards Sustainable Development: The Guelph Seminar Series. Guelph: University of Rural Planning and Development.

[16] *Ibid.*

[17] K. Muus, R. Ludke and B. Gibbens (1995). Community Perceptions of Rural Hospital Closure. *Journal of Community Health.* 20(1): 65-73.; R. Doeksen, R. Loewen and D. Strawn (1990). A Rural Hospital's Impact on a Community's Economic Health. *The Journal of Rural Health.* 6(1): 53-65.; B. Amundson and R. Rosenblatt (1988). The Rural Hospital Project: Conceptual Background and Current Status. *The Journal of Rural Health.* 4(2): 119-138.

[18] H. Dickinson and R. Torgerson (1998/99) Health Reform, Empowerment, and Community Sustainability. *Health and Canadian Society.* 5(2): 203-224.

[19] See for instance, J. Parker (1993). Rural Rage Explodes Against NDP's Health Care Reform. *Saskatoon StarPhoenix.* April 22: A8.

[20] Parker (1993).; Burton, R. (1995). Health Reform Attacked. *The Regina Leader Post.* February 11: A9.; B. Guild (1993). Communities Unite Against Government Health Cuts. *Farm Living.* September 23:52.

[21] Dickinson and Torgerson (1998/99).

2. MODELS OF DEMOCRACY

The overall theoretical stipulation here is that the regionalization of Saskatchewan health care system can be conceptualized as a site for democratization. Underpinning this statement, however, is a political debate over the role of the state in a global and highly heterogeneous society. From the dominant liberal perspective, the role and scope of the state should be kept at a minimum in order to ensure flexibility and the maximization of individual liberties. At the other end of this spectrum, however, is the maximization of the role of the state, which has the inherent danger of what Weber called the "iron cage" whereby individual liberties are subsumed under a burgeoning bureaucracy. Both trends underscore the current concern over the alienation of the modern individual from the centres of decision-making.

What is emerging, however, at both the level of theory and practice, is the increasing role of civil society. Here, the "democratic dam" against the instrumentalist rationality of bureaucracy and market imperatives is situated within the community, whereby the community members are able to deliberate over the direction of policy. The rise of regionalist imperatives can be viewed in this light. Here, the decisions over public policy are situated at the level of the community, which both minimize the role of the state while: "increasing the freedom of

choice for local communities"[1]. The question is, however, how realistic this is and how a program of deliberative democratization can be achieved without being co-opted by external forces.

Section One sets up the question of democracy in modern society by contextualizing the political debates. Section Two provides an analysis of the dominant neo-liberal model of democracy and its requisite structure of representation. Section Three takes another approach by arguing that democratization cannot fully be achieved without the active and deliberative participation of all people affected by public policy. In Section Four, regionalization is posited as a site for the institutionalization of democratization.

2.1 Democracy in Modern Society

Since the beginnings of the Greek *polis,* the substantive and normative models of democracy have been widely debated. Through modernization, however, these models have become more complex, and indeed, often more ambiguous. The main question that underscores these debates is not whether democracy is a normative ideal, but rather, how to realize a democratic structure of governance in a post-capitalist society marked by the globalization of capital and a decided attack on Keynesian state interventionism. Indeed, since the 1970s, a displacement of the centers of power (e.g. the national state bureaucracies, and state-dependent capitalist firms) has led to a certain abstraction of the relations of power. The globalization of

capital and its distancing from the control of the nation-state, for instance, has removed the relations of power and control from immediate experience, leaving the citizenry in a state of hyper-alienation and powerlessness[2]. Touraine, for instance, comments that the problems within democratic theory are premised on the feeling that the individual has no control over the decision-making, and that the representatives they have chosen do not necessarily do what is in their best interests[3]. This is particularly true if governmental decisions are made behind closed doors without any input from the citizenry.

The question of democracy, then, needs to be contextualized within the new realities of post-capitalist societies. The optimistic visions of progress coming from both Enlightenment liberals and radicals have lost their relevance in a society increasingly atomized, disparate, and managed through global economic relations. The progression of society towards harmony and social equality has become more of a normative ideal - a utopia which is pragmatically unrealizable. Indeed, in the later twentieth century, a more dismal vision of civilization emerges. For instance, Max Weber's analysis of the formal rationalization of social institutions, and the emphasis of modernist critical theory on the one-dimensional society, are examples of the shift from philosophies of emancipation (e.g. Marxism) and liberty, to ones premised on the realities of domination by bureaucracy and the transnational corporation, the depreciation of culture, the increasing concentration of wealth and control, and the over-reliance on technocratic thinking[4].

The ability of the population to believe in democracy, therefore, needs to be grounded in current economic and political realities. The rising distrust of the population in government, the rise in social group demands for self-determination, the growing rejection of the sanctity of "expert opinion" as well as the globalization of capital have led to an exhaustion of the state. Thus, a crisis in meaning has emerged. People have lost touch with the abstraction of a better life in the future, and there has been a loss of the faith that the salvation to economic woes lies in the realm of government. Rising anxieties over the misspending of funding, the burgeoning size of government, the unaccountability of political representatives, and the erosion of quality have become rooted within modern political economy. Indeed, as Ferrarotti argues: "The very notion of a State crisis is seen here as linked with the widespread perception of a growing gap between institutional performance and popular expectation"[5].

Indeed, within the centralist perspective, the state has emerged as the great Leviathan, separated from the realities of everyday life. The centralization of power, the rule of the techno-bureaucratic elite, and its inability to regulate the new economic realities have left a void in mass loyalty and thus, a crisis in meaning. Deflecting this crisis has led to two very general ideal types in modern political thought: the re-emergence of liberalism with its questioning of state intervention in the affairs of individuals, and the restriction of democracy to formal parliamentarianism and representative democracy, and the

resolution of inequality and crisis through popular participation in governance.

It is the latter that has been redeveloped in recent years as a supplement to representational democracy. Pure representation, with its emphasis on elections and parliamentary debate is argued by proponents of participatory (and now deliberative) democracy as being not just too simplistic in its conceptualization of power, but also as separating the average person from the sources of political control. Within the participatory democratic model, democratization is only realizable with the effective participation of the ordinary citizen in the decision-making process.

New interpretations of the interconnections between state, market and civil society provide some structural parameters for participation. Central to this conceptualization is the notion that the forces for political action should ideally emanate from civil society. Democratization is therefore, not merely instrumental action in the political sphere, but action which emanates from the level of a "non-state sphere comprising a variety of social institutions... which are legally guaranteed and democratically organized"[6].

2.2 Liberalism and Representative Democracy

The liberalist position emanates from the Enlightenment philosophy which sought to replace the absolutist system and religious intolerance. More specifically, the goal of the Enlightenment was to separate civil society (e.g. family, personal and business life) from the tyrannies of the state[7] and

the encroachment of bureaucratic administration[8]. Rather than having their preferences in religious doctrine, and economic and political affairs dictated by the absolutist system, liberalism stated that each individual should be able to choose his own destiny, particularly with regards to private ownership and capitalist accumulation[9]. The individual became propertied with the qualities of reason, equality, and rational thinking, which are to be used instrumentally in the accumulation of personal wealth. As Barber notes, the individual is the: "the modern privatized client-consumer who demands his (sic) rights, sells his services, contracts his relationships, votes his interests, and cost-analyzes his life-plan... a man who does not exist for others"[10].

The crisis of the state can be circumvented through the maintenance of loyalty through material rewards and the achievement of a fulfilling personal life. The free exchange of goods and services (characterized by hyper-consumerism and consumption) is a necessary pre-condition for individual freedom. The individual should not be constrained by external forces in his self-determination. The reactive forces against the absolutist system fostered the drive for minimal constraints.

The role of the state in this model should be, therefore, minimal; it exists for the instrumental purpose of the promotion and harmonization of self-interests[11]. Social progress here is determined through a lack of constraints on individualism and market competition. The freedom to act as individual agents will inevitably ensure the most beneficial distribution of welfare

among the collectivity[12]. Any impediments to this freedom, in

terms of government legislation or subsidies, will only decrease

this natural distribution of resources and power. Indeed, the

state becomes coercive when it interferes with the "natural"

processes of the marketplace:

> A free-market is the basis for a genuinely liberal
> democracy. In particular, the market can ensure the
> coordination of the decisions of producers and consumers
> without the direction of a central authority; the pursuit
> by everybody of their own ends with the resources at their
> disposal; and the development of a complex economy without
> an elite which claims to know how it all works. Politics,
> as a governmental decision-making system, will always be a
> radically imperfect system of choice when compared to the
> market. Thus 'politics' or 'state action' should be kept
> to a minimum, to the sphere of operation of an 'ultra-
> liberal' state[13].

This essentially means that state interventionism should exist

primarily for the protection of "life, liberty, and property".

Bentham for instance, argues that the state serves four

functions: to provide subsistence; to produce abundance; to

favour equality, and to maintain security[14]. Coercion by the

state occurs when there is interference with the individual's

capacity for self-determination, for instance, by enacting

legislation that serves to adjust "the material position of

particular people or enforce distributive or 'social' justice"[15].

The state, therefore, exists only if the rulers are

accountable to their constituents and protects them from the

despotic use of political power by ruling elites. There are

certain mechanisms which have been put into place to safeguard

the individual. Indeed, it is through the: "… vote, secret

ballot, competition between potential political leaders (or

representatives), elections, separation of powers and the liberty

of the press, speech and public association"[16] that the interest

of the community in general could be sustained. Liberalism, with

its procedural emphasis on representation voting, therefore,

becomes the primary means by which economic liberty and economic

good can be realized. In this respect, eligible voters elect

representatives who will be the most accountable and who are in

line with personal interests and philosophies[17].

The strength of liberalism is its practicality in a mass

democracy. Yet, liberalism has certain negative consequences for

liberty and self-government. The periodic selection of elite

representatives reduces the people's role in the determination of

policy. Moreover, as Kline notes:

> Worse, voting implies a pre-existing political
> agenda rather than one discovered and shaped
> through collective political activity, as genuine
> self-government entails; that is, liberalism
> frustrates true autonomy and self-government[18].

The ability of human beings to affect change is thus limited

within the dominant paradigm of liberal representative democracy.

2.3 Deliberative Democracy

The representative model of democracy has simply been

deemed to be more efficient in a large-scale, heterogeneous

society[19]. Yet, there has also been a growing discontent with the

primacy of the liberal democratic paradigm. While the liberal

system of representation prominent in western societies does

establish the capacity to guarantee constitutional rights and its

emphasis on representative democracy is viable in a large-scale

society, there has been, as Bohman and Rehg argue, a "… broad
dissatisfaction with the debacles and anonymity of liberal
government (e.g. the war in Vietnam and the increasing perception
that decision-making in government was bureaucratic and beyond
the control of citizens)"[20]. As a result, the modern citizen has
become apathetic – seeing decision-making as something far
removed from him or herself and therefore, their chosen
representatives as being unresponsive and beyond their scope of
direct control[21].

The lack of responsiveness and accountability has led to a
reevaluation of the primacy of liberalist politics – mainly that
modern politics requires more open dialogue between the people
and their representatives. Indeed, there has been a reawakening
of sorts of the possibilities and implications of the enhanced
political participation by the modern individual that goes beyond
the episodic voting in elections to active deliberation in policy
formation. Not only are more legitimate and better decisions
reached through discussion[22], the process itself has educational
merits[23]. Manin, for instance, argues that: "deliberation is in
itself a procedure for becoming informed"[24].

The crux of deliberative (or, more generally, participatory)
democratization is on the free articulation of public debate
through a re-emphasis on the public sphere. The public sphere
emerges as a "… discursively mediated arena of political
participation"[25]. The problem here thus becomes locating the "…
arrangements which can ground the presumption that the basic
institutions of society and the basic political institutions

would meet with the unforced agreement of all those involved, if they could participate, as free and equal, in discursive will formation"[26].

Deliberative democracy is premised upon the need to develop a will formation in which all people who are affected by the decisions are able to engage in meaningful dialogue. Indeed, deliberative democracy, according to Bohman and Regh: "... refers to the idea that legitimate lawmaking issues from the public deliberation of citizens. As a normative account of legitimacy, deliberative democracy evokes ideals of rational legislation, participatory politics, and civic self-governance"[27].

Deliberative politics comes from an interest in the political participation of individuals in political governance. For a large part, this notion of political participation stems from the tradition of civic republicanism, which sees political decisions as not just the end-result of an aggregation of individuals wills, but a process of collective will-formation. This notion of collectivity finds its roots in Aristotle, who argued that the political community is "... a community of families and aggregation of families in well-being, for the sake of a perfect and self-sufficing life"[28]. It is the common interest, therefore, that creates the political environment – people, a la Rousseau, come together under the social contract to ensure the greatest good for the greatest number of people. Political power, therefore, should not be used to further the interest of cer

tain interest groups; rather, it should reflect the common weal of the citizenry[29].

The process involved in the reaching of a common weal, however, remains substantive and normative. For the republicans, communication is at the centre of decision-making, the end result of which is the reaching of an agreement on a policy issue or common problem. For Arendt, for instance, communication about the good life is paramount to the building of common political institutions[30]. What is needed, however, is an understanding of the process for decision-making - that is, the dynamics of communication, and its infusion with power.

Thus, the Aristolian forum is underscored by the question of whose version of the good society should prevail, and, more importantly, if the political arena is able to accommodate differing versions. Civic republicanism often presumes homogeneity. As Benhabib argues, however, the republican vision of the good society, presupposes a commonality of goals and notions of the common interest[31]. In a more complex society, this may not be realistic. Decisions may reflect, therefore, the strongest voice in a community; the voices of dissenters may not be fully heard. Here, all the people involved in the decision-making process have the inherent right to communication, thus a set of procedures is needed to ensure that this occurs.

To deal with the issues of complexity and fair practice, Habermas' theory of communicative action, or more generally, discourse theory, posits that decision-making should not be based on merely a collective will-formation, but also the

institutionalization of constitutional rights that ensures
inclusion. That is, he argues that legitimate political decision-
making requires that safeguards are put into place to ensure that
everyone who is affected by a decision is able to have equality
for the articulation of their needs. In furthering Habermas'
position, Ericksen argues: "a deliberative concept of politics
has to reflect the way procedures and the system of rights
institute and regulate the political process, how they intervene
in the shaping of a collective will and in monitoring decision-
making processes"[32]. Legitimate and unhampered decisions on
public policy emanate from: "the recognition of and trust in the
procedures that ensure participation in collective will formation
and that make peaceful conflict resolution possible"[33].

Thus, Habermas' version of deliberative politics: "aims to
bring together the strategic and communicative aspects of
power"[34]. In sum, individuals could hear and evaluate opposing
views in the public sphere, and as a group could make rational
judgments which further the project of community. Public
deliberation will provide an avenue for the introduction of: "...
all moral arguments into the conversational field"[35]. This is the
ideal of a rational, consensus-oriented discourse.

Deliberative politics, therefore, cannot assume homogeneity
of opinion, but ideally, should reflect the opinions of different
people or stakeholders (i.e. become more structurally inclusive).
This requires certain presumptions about the nature and context
of deliberation. Everyone in this respect has the right to
articulate their opinion, in a context of fairness and

reciprocity[36]. Gutmann and Thompson, for instance, argue that through deliberative practices, people become disposed towards openness and the incorporation of other people's opinions[37]. Their argument, however, eschews the proceduralist approach as being immersed within the problem of not just making decisions over the substance of debate, but in deciding which procedures ensure openness[38].

While attempts have been made to develop a set of idealized deliberative practices[39], Gutmann and Thompson's critique is well taken. Often, deliberative practices remain normative and Habermas' theory of communicative action is often relegated to the realm of abstraction[40]. What he does offer is a set of constructs, which require a rethinking of the relationship between civil society, state and market (or in his dualistic model, the relationship between lifeworld and system imperatives). In his estimation, what is needed for public participation is the institutionalization of procedures that exist at the level of civil society, or the republican notion of associative life. The public sphere here emerges as a site separate from the state, which can be institutionalized with the goal of unfettered and free communication. Indeed, as Habermas argues that:

> The public sphere commandeered by societal
> organizations... can perform functions of political
> critique and control, beyond mere participation in
> political compromises, only to the extent that it is
> itself radically subjected to the requirements of
> publicity, that is, that it again becomes a public sphere
> in the strictest sense[41].

Indeed, the path to the articulation of communicative action can be achieved through the shifts in public institutions so that all the people who are affected by the decision-making are able to voice their opinions. Thus democratization requires meaningful public dialogue, not merely talk, but true deliberation, which reflect the cultural standpoint of all the social actors.

Arato and Cohen, in their article *Civil Society and Social Theory*, advance this position, arguing that a "democratic dam" can be articulated through a revitalized and democratic vision of civil society. Here, they adopt the Habermasian framework of lifeworld (the realm of culture, society and personality) and subsystems (the state and the market) to reconstruct civil society as both being acted upon by the imperatives of market and the state, but also, being active actors in governance. This goes against the one-sided vision of civil society by offering up the possibility of the "... revitalization of voluntary associations through internally democratic, open, and public forms of group life"[42].

Democratization here, therefore, means the inclusion of public spaces within political and economic spheres[43]. Arato and Cohen argue that this does not mean the overthrowing of the mechanisms of instrumental action, but rather the meaningful inclusion of the imperatives of civil society - articulated through unfettered and open discussion. Arato and Cohen, for instance, argue that victory: "... is no longer seen as the inclusion of state power (reform) or in smashing the state

(revolution) but, among the most reflective segments of the movements, as the rebuilding of civil society and *the controlling of the market economy and the bureaucratic state* (my italics)"[44]. The utopia, of full and free democracy, should therefore be self-limiting and not mired in fundamentalist quagmires. The controlling of the market economy and the bureaucratic state can be achieved incrementally, with institutional changes that allow for unfettered communication.

The opening up of public spaces for people to affect state and market imperatives has led to experiments in participation, for instance, within the workplace[45], and in within state decision-making. With regards to the latter, experiments in participatory democracy have included organized civic forums and assemblies, the goal of which was to ensure open-ended discussion with decision-makers[46]. Often these take the form of town hall meetings where the citizens meet with state officials to discuss the direction of policy.

Other experiments have dealt more explicitly with the notion of localized government. With regards to the latter, Lewis, for instance, describes the formation of "citizen leagues" which: "provide opportunities for citizens from all sectors of the community to come together, face to face, for careful deliberation on critical community issues and for problem solving and action on those issues"[47]. Explicit within the notion of citizen leagues is the notion of a commonality of goals and action oriented towards a public spiritedness. It is here that a

public space emerges to ensure that policy is inclusive of, and reflects community needs.

2.4. Institutional Change

It is within this framework that health care regionalization can be argued to be opening up a public space for deliberation. As Trottier *et al* argue, the democratization of civil society can be better institutionalized through a decentralization of decision-making:

> Decentralization should allow democracy to rest, not exclusively on the sporadic participation of the citizen-elector and on the lobbying of interest groups, but also on the daily involvement of the citizen in decision-making processes. Theoretically, this integration should allow citizens to act as co-participants in the action of elected representatives, and to refocus concern for management of public services on the betterment of individuals in their everyday lives[48].

Indeed, the location of the public sphere is of utmost importance.

While there are debates over the efficacy of democratization at the global level[49], some political theorists argue that democratization is best operationalized at the local level[50]. For instance, according to Graham and Philips, local governmental institutions: "... have played long-standing roles in the institutionalization of public participation and in the development of innovative ways to engage citizens in policy-making"[51]. Localization provides a public space for the articulation of community needs, and because of their location, they are more accessible to the local people than centralized bureaucracies.

The self-limiting utopia proposed by Arato and Cohen, therefore, is best conceptualized under local politics. Issues of public policy on many fronts, can be more readily discussed by the community members who are affected by them. Nino, for instance, explains that:

> My proposal would require that issues like abortion, criminal codes, taxation, social services, education and police protection be transferred down to the level of small political units, where all those concerned could actually meet and discuss the issues[52].

Localization, therefore, is advocated as countering the over-centralized and bureaucratic state[53].

Here, the community vision emerges as the: "best protection from the liberals' excessive individualism or the centralist totalitarianism of the state" by encouraging pluralism and enhancing flexibility and innovation in policy formation[54]. It is within this model, Trottier *et al* contend, that policy would be no longer the sole domain of powerful groups, but would open up the decision making to the citizens themselves through participatory mechanisms[55]. This, of course, depends on the citizens reclaiming their responsibility for their communities and becoming involved in the formation of policy. This means that: "politics must withdraw from its exclusively state-related domain and establish a social organization in which decisions are made as close as possible to those that are affected by them"[56]. Generally, regional governments are viewed as being more effective since they are more adjusted to local needs[57]

The regionalization of Saskatchewan's health care system, therefore, provides an interesting case study for the

possibilities of democratization. Indeed, the entire history of Saskatchewan's health care system provides an example of the influence of grassroots movements on state policies and market needs[58]. Moreover, Medicare in Saskatchewan was first conceptualized as a regional system[59]. The regional program of 1993, however, has shifted policy formation to the level of civil society and, indeed, institutionalized a set of processes that ideally set up a public space for the active deliberation of community members in policy formation.

Indeed, within the present structure, local people, not the centralized state, have control over policy formation, and have important decision-making powers. What is important here too is that in Saskatchewan, the majority of the people able to make policy decisions are elected by local people. Added to this, one of the goals of health reform in Saskatchewan is to ensure more community participation - thus setting up the conditions for a more bottom-up mode of policy formation. The structure, therefore, reflects a situation where power is located at the level of civil society. The extent to which this is pragmatic, or realizable, is another issue.

Indeed, the new district health boards, created by the *Health Districts Act* of 1993, create a new institution that is structurally positioned to institutionalize public participation, but are lessons to be learned by history. The success can be measured, at least in part, by the ability of the district boards to ensure that they do not become the sites by which centralized bureaucracies and market imperatives fully dictate health care

policy. They may emerge as "mini-bureaucracies" which serve to further entrench the top-down model of governance.

There are other issues that need to be addressed. It is difficult to suggest, for instance, that atomic individuals with varying degrees of social position, expectations and beliefs can come together to make decisions that are good for the community as a whole. The reality of plurality, and the issue of power relations, for instance, impose difficulties in the overall design. One aspect of this is the domination of policy decisions by professional and interest groups. The experiments in citizen participation noted by Button and Mattson, for instance, became enmeshed within discourses of mystification, and the relationships between citizen and state officials reflected passivity and deference[60]. Indeed, they argue that experiments have shown that an approach to participatory practice:

> … shifts the possibilities of an open-ended, lateral dialogue into a stilted, one-directional exchange that reenacts political inequalities and fosters deference and passivity. In practice, deliberation in practice may not be democratic; nor will it necessarily transform pre-exist political relations[61].

An obvious issue here then, is how well the model of community participation can be effectively institutionalized in a political system that reflects technical and political expertise[62].

Moreover, there is the possibility that information has already been filtered through the mechanisms of media and power; thus, the parameters of decision-making are already formed. For instance, people's notions about privatization may be influenced by media reports over the need to cut costs and streamline the

state. Another possibility is that people will simply not become active due to a lack of interest or a cynicism that their voices will not necessarily be taken into account.

Yet, while political theorists may bemoan the reality of an apathetic citizenry, creating a public space for their participation may be one step in making people more interested in politics, and thus more likely to participate, particularly if their voices are actually listened to. It is a matter of taking ownership of public policy.

NOTES

[1] L. Trottier et al (1999). Contrasting Visions of Decentralization. In D. Drache and T. Sullivan (eds). *Market Limits in Health Reform: Public Success, Private Failures.* London: Routledge. p. 147.

[2] G. Kline (1994). Democracy, Community, and Human Development. *Journal of Third World Studies.* 21(1): 224-244.

[3] A. Touraine (1997). *What is Democracy?* Boulder, Colorado: Westview Press. p. 8.

[4] See for instance, H. Marcuse (1964). *The One-Dimensional Man.* Boston: Beacon Press; and Friedman, G. (1981). *The Political Philosophy of the Frankfurt School.* Ithaca, N.Y.: Cornell University Press.

[5] F. Ferrarotti (1984). Civil Society and State Structures in Creative Tension: Ferguson, Hegel, Gramsci. *State, Culture and Society,* 1(1). p. 3.

[6] D. Held and J. Keane (1984). In a Fit State. *New Socialist.* Vol. 16. p. 38.

[7] D. Held (1996). *Models of Democracy (2nd edition).* Stanford: Stanford University Press, Chapter 3.

[8] P. Hirst (1996). Democracy and Civil Society. In. P. Hirst and S. Khilnani (eds). *Reinventing Democracy.* Blackwell Publishers: Oxford.

[9] The use of the gender specific term "his" is intentional. The individual propertied with reason was not a universal figure. The rights to life, liberty, property, and political activity were first the males of the new middle class, or bourgeoisie. Conflicts, such as the suffrage movement, later made self-determination a more universal concept.

[10] B. Barber (1984). *Strong Democracy.* Berkeley: University of California Press. p. 71.

[11] G. Kline (1994).

[12] G. Underhill (1994). Conceptualizing the Changing Global Order. In R. Stubbs and G. Underhill (eds). *Political Economy and the Changing Global Order.* Toronto: McClelland and Stewart.

[13] D. Held (1996). p. 260.

[14] J. Bentham (1960). *Fragment on Government.* Oxford: Basil Blackwell.

[15] F.A. Hayek (1960). *The Constitution of Liberty.* London: Routledge and Kegan Paul. p. 231.

[16] D. Held (1983). Introduction: Central Perspectives on the Modern State. In D. Held et al (eds). *States and Societies.* New York: New York University Press. p. 15.

[17] Eligibility at first was very exclusionary. Mill's vision, for instance, of the pluralistic system of voting was graduated through property ownership and occupation. The wiser and more talented, thus, should have more voting rights than the ignorant and less able. The working classes, therefore, could not outvote those with more social privilege and property.

[18] G. Kline (1994). Democracy, Community, and Human Development. *Journal of Third World Studies*. XI(1). p. 235.

[19] P. Hirst and S. Khilnani (1996). Introduction. In. P. Hirst and S. Khilnani (eds). *Reinventing Democracy*. Blackwell Publishers: Oxford.

[20] J. Bohman and W. Regh (1997). Introduction. In J. Bohman and W. Regh (eds). *Essays on Reason and Politics: Deliberative Democracy*. Cambridge: The MIT Press. p. x.

[21] J. Fernia (1996). Complexity and Deliberative Democracy. *Inquiry*. Vol. 39. p. 359.

[22] J.D. Fearon (1998). Deliberation as Discussion. In J. Elster (ed): *Deliberative Democracy*. Cambridge: Cambridge University Press.

[23] A. Gutman (1987). *Democratic Education*. Princton: Princeton University Press.

[24] B. Manin (1987) On Legitimacy and Political Deliberation. *Political Theory*, 15(3), p.349.

[25] M. Alario (1994). Environmental Destruction and the Public Sphere: On Habermas's Discursive Model and Political Ecology. *Social Theory and Practice*. 20(3). p. 327.

[26] Quoted in S. Lukes (1982). Of Gods and Demons: Habermas and Practical Reason. In. J. Thompson and D. Held (eds). *Habermas: Critical Debates*. Cambridge, Massachusetts: The MIT Press. p. 138.

[27] J. Bohman and W. Regh (1997) *Essays on Reason and Politics: Deliberative Democracy*. Cambridge, MA: The MIT Press. p. ix.

[28] Cited in Axtmann (1996). *Liberal Democracy into the Twenty-First Century: Globalization, Integration and the Nation-State*. Manchester: Manchester University Press, p. 49.

[29] R. Axtmann (1996).

[30] *Ibid*.

[31] S, Benhabib (1992). *Situating the Self. Gender, Community and Postmodernism in Contemporary Ethics*. New York: Routledge.

[32] E. Ericksen (1999) *The Question of Deliberative Supranationalism in the EU*. Arena Working Papers. http://www.arena.uio.no/publications/wp99_4.htm#Title note. Accessed July, 2001.

[33] *Ibid*.

[34] Axtmann, (1996) p. 53.

[35] *Ibid*. p. 6.

[36] A. Gutmann and D. Thompson (1996). *Democracy and Disagreement*. Cambridge, Mass.: The Belknap Press of Harvard University Thompson.

[37] *Ibid*.

[38] A. Gutmann and D. Thompson (1997). Deliberating about Bioethics. *Hastings Center Report*. 27(3): 38-41.

[39] J. Cohen (1998). Procedure and Substance in Deliberative Democracy. In J. Bohman and W. Rehg (eds.): *Deliberative Democracy*. Cambridge, Mass.: The MIT Press.

[40] R. Blaug (1996). New Developments in Deliberative Democracy. Politics. 16(2): 71-77.

[41] J. Habermas (1989). *The Structural Transformation of the Public Sphere: An Inquiry into a Category of Bourgeois Society.* Cambridge, MA: The MIT Press. p. 208.

[42] A. Arato and J. Cohen (1991). Civil Society and Social Theory. In P. Beilharz. G. Robinson and J. Rundell (eds). *Between Totalitarianism and Postmodernity: A Thesis Eleven Reader.* The MIT Press: Cambridge. p. 209.

[43] *Ibid.*

[44] *Ibid.* p. 215.

[45] R. Mason (1982). *Participatory and Workplace Democracy: A Theoretical Development in Critique of Liberalism.* Carbondale: Southern Illinois University Press.

[46] Such experiments include the citizen assemblies organized by the League of Women Voters in the United States where meetings were held between citizens and the members of Congress to discuss campaign finance reform, and the Citizen's Jury on Health Reform held in Washington D.C. where a random selection of citizens met with members of Congress to discuss the direction of the American health care system. These types of experiments are described in M. Button and K. Mattson (1999). Deliberative Democracy in Practice: Challenges and Prospects for Civic Deliberation. *Polity,* 31(4): 609-37.

[47] R. Lewis. (1994). Citizen Leagues: Free Spaces of Deliberative Democracy. *National Civic Review.* 83(Winter). pp. 472-473.

[48] L. Trottier *et al* (1999). p. 149.

[49] See for instance, R. Dahl (1999). Can International Organizations be Democratic? A Skeptic's View. In I. Shapiro and C. Hacker-Cordon (eds). *Democracy's Edges.* Cambridge: Cambridge University Press.

[50] C. Nino (1996). *The Constitution of Deliberative Democracy.* New Haven: Yale University Press.

[51] K. Graham and S. Philips (1998). Making Public Participation more Effective: Issues for Local Government. In K. Graham and S. Philips (eds). *Citizen Engagement: Lessons in Participation from Local Government.* Toronto: IPAC. p. 1.

[52] C. Nino (1996). p. 152.

[53] J. Stewart (1996).

[54] L. Trottier *et al* (1999). p. 159.

[55] *Ibid*

[56] *Ibid.* p. 160.

[57] J. Friedman (1992). *Empowerment: The Politics of Alternative Development.* Blackwell: Cambridge.

[58] See for instance, H. Dickinson (1993). The Struggle for State Health Insurance: Reconsidering the Role of Saskatchewan Farmers. *Studies in Political Economy.* Volume 41; and S. Wolfe and R. Badgley (1967). *The Doctor's Strike: Medical Care and Conflict in Saskatchewan.* Toronto: MacMillan of Canada.

[59] See for instance, Feather, J. (1991). Impact of the Swift Current Health Region: Experiment or Model. *Prairie Forum.* 16(2): 225-248

[60] M. Button and K. Mattson (1999).

[61] *Ibid.* p. 629.

[62] *Ibid.*

3. HEALTH CARE REGIONALIZATION

Chapter Three makes the connection between health care regionalization and democratization. In the first section, regionalization is contextualized within the Canadian health care "crisis". The "crisis" is essentially a perceived irreconcilable contradiction between maintaining a quality health care system while ensuring its economic and structural sustainability. Section Two introduces regionalization as an instance of institutional change in health care. Later on, the possibilities for democratization inherent within regionalization are explored. The past experiments in regionalization, for instance, are developed since they provide a good background for the issues related to the democratization of the health care system.

3.1 Canadian Health Care Reform

Medicare, a system of publicly funded health care remains one of Canada's crowning achievements, symbolizing the Canadian commitment to social equality and universalism. The *Canada Health Act* passed in 1984 assures Canadians that quality care will be universally available, regardless of ability to pay, geographical location, or social group[1]. Yet, while this public program remains important to Canadians, and is a strong symbol of

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Canadian unity, its legitimacy as a public institution is being undermined in the political economy of privatization, non-interventionist policies and the ensuing erosion of the welfare state.

Essentially, the crisis in Medicare is one of balancing the political ideology of cost containment with the valued principles of Medicare guaranteed under the *Canada Health Act* including portability, universalism, comprehensiveness and public administration[2]. Indeed, the sustainability of Medicare has come under attack from all points on the political spectrum, the common denominator of these attacks is the growing costs of the system and declining public expenditure to pay for these costs[3]. The causes for these costs are varied. They include the over-reliance on institutional care[4], the fee-for-service remuneration for Canadian physicians[5], the rising costs of technologies[6] and pharmaceuticals[7], and the rising population of the elderly[8].

The politics of health care reform are thus framed within a ideological trepidation over the inability of the system to deal with ever-increasing health care costs. The projected health expenditure for the year 2000 is over $95 billion[9]. Of this, about seventy percent is spent through public funding[10]. Drug costs, medical equipment, home care, health insurance, as well as other related private costs take up the remaining resources.

However, if one looked at the costs more carefully, the issue of cost escalation may be due more to political rhetoric than reality, especially since Canada's record of cost control

has been good[11]. Burke and Stevenson point out that the political

discourse over health care costs are marred by inconsistencies:

> The proposition that health-care costs were spiraling out
> of control became a political issue only in the 1970s, at
> the very moment that these costs stabilized, after two
> decades of steady growth, at just over 7 percent of the
> Gross National Product[12].

It would seem then, that the crisis over Medicare has in part

been grounded within the "ideology of free market hegemony that

constructs government intervention in health as an unnecessary

and malign imposition on market forces"[13]. Neoliberalist

economics, therefore, are being reintroduced in the health care

field. Yet, at the same time as it is reducing financial aid to

the provinces, the federal government is upholding the ideals of

Medicare through the *Canada Health Act*[14]. This duality of state

intervention and market pressures creates an inconsistency over

the functioning of the Canadian health care system.

Indeed, the debate over Medicare has become what Iglehart

likens to a "pressure cooker that is building up steam on a hot

stove"[15]. While the government attempts to reduce costs by

freezing transfer payments to the provinces[16], universal access

to health care remains very popular among Canadians. Moreover,

studies have found that Canadians would be willing to pay more in

taxes if it means maintaining Medicare[17]. Since Medicare is a

"sacred trust", it is not politically feasible to instigate any

massive fiscal reforms without the support of the populace. The

Canadian federal and provincial governments, therefore, must

develop a balancing act between the pressures of the fiscal

demands of the global free market (the reduction of the role of

the state) and the demands of the Canadian population for a publicly funded health care system.

The balancing act has been more pressing with the actualization of cost control measures undertaken by the federal government in recent years. In the 2000 federal budget, the federal government increased the funding to the Canada Health and Social Transfer (CHST) by 2.5 billion dollars[18]. In the 2000 budget, it was estimated that the total Canadian Health and Social Transfer would reach close to $31 billion by 2001[19]. Moreover, in a mini budget speech before the 2000 election, the federal government committed $21.1 billion to the CHST over a five-year period[20]. This offsets the cuts to the Canadian Health and Social Transfer that have occurred since the 1980s. In 1986, for instance, the federal government began cutting the transfer payments earmarked for the health care funding and post-secondary education[21]. During the eighties, the cumulative loss of revenue for provincial budgets amounted to $30 billion[22].

The result is that the provinces have been put in the difficult position of offsetting the cuts to their health care coffers. There is a need, therefore, to reform the health care system, which encompasses reducing health care costs while maintaining quality care for Canadians. At the crux of this need is interplay between the roles of the state, market and civil society.

The neoliberalist vision of health is the minimization of state intervention in health care and the expansion of privatization in health care insurance and service provision[23].

The argument here is that private enterprise is better able than the bureaucratized state to enhance the flexibility within the sector, and "… offer a larger choice of responses to the diversified needs of individuals"[24]. The solution here is thus to privatize services (e.g. de-listing medical procedures and pharmaceuticals from public services, instituting user fees and double billing for physician care, forming private hospitals, and/or contracting out services such as laboratory services). Yet as Trottier *et al* contend, while the move towards market forces serves to ensure more flexibility and diversification, it does not serve to manage costs[25]. Indeed, according to many health economists, privatization only serves to increase costs[26].

Here, the notion of localized control emerges as an alternative to the privatization of health care provision and management, and possibly, to the bureaucratic red-tape of the centralized state. Trottier *et al* argue that decentralization creates a more flexible system that also serves to ensure the mechanisms of social solidarity and the redistribution of wealth found within the centralist approach[27]. Inherent within the decentralized approach is the notion of self-management, and the "… affirmation of differences among local communities"[28].

But more, decentralization emerges at a time when the state is being questioned as emerging as the Leviathan, separate from the citizen and thus unable to adequately respond to their needs. Localizing the decision-making, it is theorized, would expand the conditions for public participation in health care decision-

making[29]. Underscoring this is a recent revaluation for public participation in health care decision-making. MacKean and Thurston, for instance, argue that several movements have contributed to the current philosophy on democratic participation in health care:

> First, the consumer movement has introduced changing expectations. Second, the women's movement has generated pressures for change, the concerns including a lack of information, lack of respect, lack of participation in the decision-making process, and lack of access to appropriate services. Third, there are pressures from the baby-boom generation who bring to the consumer role expectations of self-fulfillment, a strong skepticism, and a willingness to challenge and change institutions. Finally, there is a general growing dissatisfaction with and distrust of institutions in society[30].

Indeed, the trends in health care services has been affected by the rise of demands for more consumer involvement in health care, not just at the individual/patient level, but at the level of planning and decision-making in overall health policy[31]. The World Health Organization, for instance, has advocated for more public participation in health policy. The 1965 Report of the Royal Commission on Health Services argues that there is a connection between the health of the population and public participation: "… the achievement of the highest possible health standards for all our people must become a primary objective of national policy and a cohesive factor contributing to national unity, involving individual and community responsibilities and actions"[32].

The realization of localization in the form of regionalization posits the decision-making at the level of civil society, creating an institution (or free space), which allows

for the public participation within health care policy. The promises here is perhaps an effective vanguard against the incursions of market and state forces in which people are able to come together to make the decisions about an important public institution. The promise here is therefore the realization of public participation and the free exchange of ideas. The danger here, as can be discerned from the literature on past experiments with regionalization, is that the regional boards will emerge as "mini-bureaucracies", which only serve to reinforce already entrenched power relations (e.g. techno-bureaucrats and health care professionals).

3.2 Institutional Change

The regionalization of health care in Canada is premised on a program of rationalization intended to reduce costs and increase efficiency. For instance, a regional program is intended to reduce the duplication of services inherent in a system of institutional boards and to enhance the coordination of service provision[33]. But more, regionalization means a transfer of service provision and decision-making to the community, which has important ramifications for the democratization of health care planning and service delivery.

3.2.1 Devolution

Indeed, regionalization is the "… transfer of some degree of power from a central authority to a smaller geographical/population base"[34]. It also means an element of centralization as "… powers formally at the local level may be

concentrated to a new regional level"[35]. That is, health care

regionalization replaces the informal power of providers (e.g.

individual hospital and community care boards) with a smaller

number of regional boards[36]. Here, the structural inefficiencies

caused by the duplication of services and the competition of

hospital and community care boards for scarce health care funding

would be reduced, and ideally, eliminated[37]. Indeed, each region

would be given an envelope of pooled funding from which they

could "… reallocate resources according to the needs of the

population served"[38].

As Rachlis and Kushner argue, regionalization has several

possible positive outcomes:

1. Decisions would be made closer to the action. Mistakes will
   be discovered earlier and can be corrected without needing to
   wait for approval from some central authority;
2. It provides a basis for pooling resources and a mechanism for
   reallocation;
3. It reduces complexity by limiting the number of stakeholders
   and establishments that have to be dealt with; and
4. It expands the chances for public participation[39].

Thus far, nine out of the ten provinces have regionalized

their health care agendas, the only exception being Ontario[40].

Each provincial program of regionalization varies, from a "…

limited power over hospitals (New Brunswick) to extensive

resource allocation and other powers over a combined budget for

community services, welfare, housing, corrections, and almost all

health care (Prince Edward Island)[41]. The meaning of

regionalization is thus unique to each province. But as Lomas et

al. posit, the regional authorities are relatively uniform across

Canada with regard to the degree of decision-making authority.

They thus state that "… none of the boards has any role in raising revenue (except that some collect local contributions for the capital costs of new construction), but all are responsible for local planning, setting priorities, allocating funds and managing services for greater effectiveness, within provincially defined core services"[42]. The regional authorities usually take care of human resources for their area, excluding the hiring of physicians (although some have the planning of physician resources within their mandate)[43]. The provincial bureaucracies typically retain the authority to raise revenue and determine core services[44].

Under a program of regionalization, there is typically some degree of devolution or decentralization of authority to the regional level. Devolution means that authority for decision-making is transferred to a local authority with only broad principles being controlled by a centralized government[45]. The transfer of control in this respect is believed to increase local access to decision-making processes, thus facilitating a program of participation and direct democracy. In a report by the Ontario Premier's Council on Health, Well-Being, and Justice, it was observed that devolution has the potential for:

> ...cost containment, improved consumer participation in decision-making (with respect to both the allocation of health and health care resources and the delivery of services), improved integration and coordination of services, and greater responsiveness to local needs[46].

Essentially, this means locating control for health care decisions at the level of civil society whereby the people affected by the decisions have more control over how health care

dollars should be spent according to their unique, albeit complex, cultural standpoints.

The cost control factor is simple. By shifting the decision-making closer to the people, the actual health needs of the people would be easier to discern and costs would therefore more directly represent local characteristics[47]. But more, the very structure of a devolved authority creates opportunities for public participation by the people who are directly affected by the decision-making. As Dahl, notes, localizing the decision-making could lead to the participation of the public in the decision-making which directly affects them:

> The larger scale of decisions need not lead inevitably to a widening sense of powerlessness, provided citizens can exercise significant control over decisions on the smaller scale of matters important in their daily lives: education, public health, town and country planning, the supply and quality of the local public sector; from streets and lighting to parks and playgrounds and the like[48].

The issue of local decision-making implies that the local officials will have the power to make the decisions that they believe to be best for their area. Huntington, for instance, argues that there is a possible link between local control and regionalism: "The autonomy of political institutions is measured by the extent to which they have their own interests and values distinguishable from those of other social forces"[49].

Another possible consequence of regionalization is that the local officials will become more responsive to local issues[50]. Putnum, for instance, argues that responsiveness means responding to the needs of the populace: "Good government is more than just

a forum for competing viewpoints or a sounding board for complaints; it actually gets things done"[51]. Saskatchewan Health, for instance, makes the connection between regionalization and responsiveness in their document *A Saskatchewan Vision for Health*. It is thus stated that "… the wellness approach will create a health system that is responsive to community needs by placing control and management responsibilities at a local level"[52].

3.2.2 Local Elections

The localization of control also has meaning not just for how decisions are made but who makes them. The appointment of board members does not necessarily translate into non-partisanship[53]. Within the current restructuring process in Canada, the board members are, or will be, elected by the local people[54]. In Saskatchewan, for instance, 67% of the regional health board members are elected by the local people[55]. Electing local people to the boards ensures a public mandate which "… confers on boards a degree of legitimacy often denied to appointees"[56]. Elected boards, therefore, are intrinsically tied to the issue of local governance since it could translate into a more accountable and responsive system[57].

The election of regional health authorities creates, therefore, the conditions by which the decision-makers are directly accountable to the population. Jones, for instance, when arguing for the election of National Health Service (NHS) in England, argued that the election of the health authorities would

make them more directly answerable to the local people. They thus

argue that "... nevertheless, it is clear that the [appointed]

members lack of clear basis of authority"[58]. Localized elections,

then, are argued to increase the accountability of the decision-

makers[59]. Moreover, the institutionalization of local elections

is premised on the model of representative government. The ideal

of electing officials is to ensure that they 'mirror' in their

social characteristics, those they were elected to represent and

thus serve their best interests[60].

3.2.3 Participation

Moreover, regionalization has the possibility for the

institutionalization of community control and participation in

significant health care service provision and resource allocation

decisions. According to Denis *et al.*, most of the regional health

boards operate on a democratic model that favours public

participation, respecting diversity, and incorporating

participation of citizens within the formulation of public

policy[61]. British Columbia, Quebec, Nova Scotia and Prince Edward

Island have incorporated some aspects of this model into their

regional authorities. But it is Saskatchewan, they argue, that

has gone the furthest in formally democratizing its health care

system[62]. Democratization, therefore, emerges through the active

and inclusive participation of all the people affected by the

formation and execution of public policy[63]. Indeed, participation

is "... the deliberative active engagement of citizens by the

council and/or administration - outside the electoral process -

in making public policy decisions or in setting strategic directions"[64].

3.3 Regionalization and Democratization

Yet, while there is an expectation that regionalization will enhance democracy, Denis *et al.* argue that it may be more ideal than real. They point out that regionalization may only serve to create yet another level of bureaucracy which would further remove citizens from the centre of decision-making[65]. The amalgamation of institutional boards into a regional authority, for instance, could effectively hamper the involvement of the local people in direct decision-making. Lewis makes this connection:

> While regionalization appears to add a new layer of government, it can also wipe away a huge governance apparatus of local institutional and agency boards. Not only are there usually far fewer boards and board members after restructuring, in many communities (particularly in rural areas), the locus of power is entirely removed; every local program and service is accountable to the regional board[66].

At issue here, however, is the quality of board decision-making. What needs to be addressed is not just the number of institutional and agency board members displaced by regionalization, but what their role was in the decision-making process.

Therefore, the connections between democratization and regionalization are not very clear-cut. Indeed, as Lomas *et al.* argue, the move towards the recent trend in devolution is a "leap in the dark"[67]; little is known about the ramifications of

localizing health care governance for a program of democratization.

What *is* known about the connection between regionalization and public participation has not been altogether clear, nor has it been always positive. The early experiences of Quebec with regionalization, for instance, provide an example of its possibilities and pitfalls. Quebec began experiments with regionalized health and social services in the 1970s, with the goal of bringing decision-making closer to the people. This reform was mainly due to the recognition that the centralization of decision-making within the Ministry of Health and Social Services was not able to adapt quickly and efficiently to the changing and unique needs of the population. Bringing the decision-making closer to the people therefore, meant more flexibility in decision-making and a public institution which could adapt to change. Furthermore, it meant creating a forum by which the people themselves could articulate and debate the allocation of resources and make the decisions about health care which directly affected them[68]. The reform was premised on the inclusion of community participation - a principle guaranteed by law[69].

The structural changes came about due to the very influential *Castonguay Report* written in 1970 by the Commission of Enquiry into Health and Social Welfare. The principles underscoring this report were equity and efficiency: "... equity in the sense of reducing the substantial gap in health status

between the small, wealthy minority and the massive *classe*

populaire, or working class, as well as between urban and rural

dwellers; and efficiency in the sense of ensuring the greatest

possible gains without losing control over costs"[70]. Guided by

these principles, the report suggests broad base structural

reforms to Quebec's health care system. For instance, the bio-

medical model of health care which posed the doctor as the only

expert, was to be replaced by a multidisciplinary team which took

into account the economic and social issues affecting health[71].

This meant taking into account the experiences of the whole

person and their social environments, not just their physical

ailments.

In order to accomplish a more multidisciplinary and holistic

approach, health care and social services were amalgamated. Thus,

in 1970, the Department of Health and the Department of Social

Services were combined into one entity, the Department of Social

Affairs. It was through this new department that *Bill 65*, a

program of regionalized health and social services, was

promulgated and passed. In essence, *Bill 65* radically changed the

structure of health care and social services through the creation

of 12 administrative regions in the province[72]. Each region was

governed by the principles of democratization, mainly by

providing for the active participation of both professionals and

community members (or "lay" people) within the decision-making

process. For instance, the Regional Bureaus were composed of

appointed representatives from the universities, the hospitals,

the local service centres, as well as representatives from the "socio-economic groups within each region[73].

Within each Region were four types of centres: the Local Community Service Centres (LCSC) which was intended to provide a very broad range of ambulatory health and social services; the hospital centres; the Social Service Centres, which had the mandate to provide social action services, such as foster homes, adoption services, etc...; and finally, the Reception Centres which took care of those people who needed assistance or lodging because of physical, personality, family or age reasons[74]. Each Centre was administered by a Board of Directors, of whom half were to be elected by the local people. In 1971 legislation was passed to ensure that there were four "lay" people on the boards of directors: two were to be elected and two were to be appointed by the provincial government to assure social parity[75]. The inclusion of local people on the boards was meant to offset professional dominance over decision-making.

Yet the promise of this system for democratization was not entirely fulfilled. The community representatives on the CLSC and hospital boards were not fully effective in influencing the system and were often viewed by professionals as contributing to inefficiency and time losses[76]. While there were instances of genuine citizen control over the decision-making[77], in the end, the decision-making for both the CLSC's and hospital boards were dominated by professional interests and special interest groups. Often this was due to the technical language being used by

professionals to make decision-making more complex for the layperson[78].

The case in Quebec, then, showed that the primary actors in the decision-making are professionals and interest groups rather than the local citizens[79]. Bjorkman, in a comparative study of health care services in Britain, Sweden and the United States, concurs with this assessment:

> Yet when citizens sit on planning boards, operational committees, and health councils, lay participants are rarely active. The agenda is set by the chairperson in consultation with the professional staff of experts and administrators. Due to time constraints and background knowledge, lay participants have little basis on which to discuss technical matters, so they usually accept staff recommendations... As a result, policy and program options are routinely endorsed and legitimated by the citizen boards[80].

The possibility thus exists that the participation does not necessarily translate into better decisions. As Yeo argues: "this view pits expert decision making against public participation, denigrating the later on the grounds that the public is not well suited to play a significant part in resource allocation decisions"[81]. Thus, the local decision-makers may only rely on the information which has been codified, refuted, and validated by experts. Community knowledge, on the other hand, could be relegated as myth, mere opinion and emotional responses, and not useful to the decision-making process[82]. This restricts the information transfer from the people to the local government, and could affect the responsiveness of the governors to the local population.

The lessons learned from Quebec are that a balancing act must be performed by regional boards to allow for the voices of all the stakeholders involved. This means, perhaps, going beyond ensuring the representation of local citizens on the boards to a participatory model of democratization whereby new processes and procedures are introduced to allow for self-government[83]. Indeed, the development of a more participatory democratic model was influenced by the influx of participatory political actions, for instance, "direct democracy, town hall meetings and small organizations, workplace democracy, mediated forms of public reason among citizens with diverse moral doctrines, voluntary associations, and deliberative constitutional and judicial practices, just to name a few"[84].

In the Quebec case, the voices of the citizenry were reduced to the voting of certain representatives to the board of directors. What was perhaps needed were procedures and mechanisms for the inclusion of all people within the decision-making process. That is, democratization should mean more than who is able to voice their opinions in the board meeting; rather, the decision-making process should reflect a more holistic approach, encompassing the active participation of the citizenry through a means which goes beyond holding the decision-makers accountable through local elections[85].

The mechanisms that have been proposed include the restructuring of public meetings to ensure that all the people are invited to voice their opinion and that there is an effective deliberation of opinions rather than the mere presentation of

information by the local representatives. Stewart, for instance,

posits that:

> Public meetings convened by local authorities often follow
> the tired pattern of platform presentation followed by
> questions from the floor - a format more likely to lead to
> protest through public frustration than to encourage
> deliberation[86].

Here, participation becomes more reactive, rather than

incorporating the opinions of the community members.

Moreover, it is possible that the decision-makers are not

representative of the community they serve, thus entrenching

certain interests or even successively replacing one hierarchy

with another. This was certainly the case with Quebec where

antagonism existed between the lay personnel and professionals[37].

But more, local governance could be dominated by certain

interests while excluding others, in particular racial

minorities, women, or economically disadvantaged groups.

Dickinson, for instance, argues that there are dangers in

ignoring pre-existing social inequities already operating within

society:

> The greater involvement of communities in needs-assessment
> and service delivery decisions assumed and encouraged by
> health promotion may be Janus-faced. Increased
> participation in defining problems and solutions
> politicizes those processes. ... Negative effects of
> politicization are related to the fact that power and
> other resources are not equally distributed throughout
> society or within communities. Existing inequities, then,
> may be further entrenched and exacerbated through the
> political process. If politicizing health-care policy and
> practice does not result in democratization, it may
> contribute to an entrenchment or extension of existing
> inequities[88] .

Decision-making may end up representing the interests of dominant

groups, be they professional groups, or economically advantaged

groups. The inclusion of all the groups within the community is imperative both within the board structure and within the means of participation to ensure true democratization.

Moreover, the whole concept of health itself poses certain problems for a devolved system of governance. The problem of a lack of citizen knowledge as noted before poses a problem for citizens confronted with complex jargon and ideas. People may simply give way to the advice of professionals and techno-bureaucrats. An ingrained medical dependency typically translates into the acceptance that health professionals simply "know best" since they supposedly have a better grasp of health care issues[29]. Thus, as MacKean and Thurston argue: "Due to actual and/or perceived complexity of health care issues, it is important that public participants have access to complete and unbiased information upon which to comment and to aid in making decisions. The disparity of knowledge between health professionals and members of the public is often cited as an obstacle to public participation in the health sector"[30]. The sharing of information from the expert and the bureaucrats is thus necessary for the inclusion of non-experts within the decision-making. This would be more easily facilitated through open communication between all the stakeholders as well as through training programs.

Citizen apathy is another important consideration when assessing the democratization of the health care system. Often, people will only wish to be consulted and "expect and prefer that 'the experts' take responsibility for actually making the

decisions"[31]. But more, illness is often episodic; therefore, people only intermittently are interested in health care governance. As Bjorkman argues: "If people are generally not sick, then more pressing day-to-day concerns will direct their attentions elsewhere. Who, then, should keep a vigilant eye on the actions and operations of the health services sector?"[32].

Bjorkman further notes that there is a low interest in participating in the decision-making, then the representatives who are instead elected may only represent the interests of special interest groups, or professionals[33]. Thus, "… if interest is low and the issues few, then only the most salient interests of the community as a whole will be reflected in the process of selecting those who control health services"[34]. As Marmor further notes: "it is almost impossible to have local representatives – however chosen – except by quota – mirror the community from which they spring"[35].

Another issue here is low voter turnout. In the 1995 Saskatchewan health board local elections, for instance, only an average of 35% of the population came out to vote[36]. As Lomas et al. argue, this low voter turnout "… does not bode well for citizen representation"[37]. It also leaves the door open for special interests and professional dominance. Tuohy and Evans, for instance, argue that: "A mandate drawn from substantively less than 35% of the voting population does not constitute a very effective political resource in dealing with cohesively organized provider groups"[38]. The very real possibility is that public participation may only open the door to the "… increased

politicization of health planning to special interest groups, lobby groups, and so on"[99]. The issue of local representation, then, is adversely affected by low voter turnout[100].

Moreover, even if people wish to proactively participate in the decision-making, time pressures may make it more difficult. Participation in board meetings, for instance, may be more difficult if one has child care responsibilities or is working two shifts[101]. Another version of this is the notion that democratic participation itself is simply too time-consuming and therefore its implementation is unrealistic[102].

A program of regionalization also means some form of devolution whereby decision-making powers are transferred from a centralized bureaucracy to a local board or council. What is at issue here, however, is whether or not this transfer of power is real or merely a smokescreen for the intentions of the centralized bureaucracy.

Putnam, for instance, in investigating the devolution of authority to regional governments, found that while regionalization was intended to transfer authority to the local level, the central bureaucracies were not willing to fully give up control. The central authorities utilized mechanisms to maintain control, such as acts of veto, and a control over money:

> During those early years, an alliance of conservative national politicians, an entrenched national bureaucracy, and a traditional-minded judiciary combined to impose numerous legal, administrative, and fiscal restraints on the regions. The central authorities regain general powers of "direction and coordination" over regional affairs, and they did not hesitate to use those powers. For example, roughly one-quarter of all the laws passed by the regions during the first legislature were vetoed by the central

administration. Moreover, the central government kept a tight grip on the purse strings of the new governments[103].

The implementation of regional boards, therefore, is only one component of the reform - the actual application of the formal rules by the regional boards and the provincial government is another[104]. The realization of devolution, as Lomas argues, requires that the regional boards are willing and able to take control over their local decision-making, and that the provincial government is willing and able to let them take this control:

> Therefore, just where a province's local or regional bodies lie on this de-something spectrum will, to a significant degree, depend on the attitude and approach of the local board - their willingness to grab the power and run with it until they are stopped - and the attitude of the provincial government - their tolerance, for instance, of local boards that diverge from the central objectives of cost containment, health outcomes, and so on, as well as their willingness to allow significant variations in service delivery patterns to emerge across their province in the name of "local preferences"[105].

The connection, then, between devolution and democratization, may be based more on rhetoric than reality. Paternalistic structures of control, for instance, need to be replaced with one that requires a more autonomous local government. The extent to which this is realized, therefore, is an important point for investigation.

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4. METHODOLOGY

The fourth chapter develops the methodology utilized
for this study. First of all, democratization is
conceptualized. Theoretically, democracy is an
aggregation of the institutional changes implicit within
Saskatchewan's program of regionalization. The
institutional changes that occurred are devolution,
local elections, and, a value placed on community
participation. Each aspect contributes to the overall
democratization of health care decision-making. The
ideal here is not one of transcendentalism; rather, the
study is based on the notion of self-limitation. Health
care, therefore, is only one element of an overall
project of democratization. But it may serve as a model
for other areas of public policy and institutional
reform.

Section Two describes the overall research design.
The emphasis of the study is on describing how
regionalization has been implemented in Saskatchewan and
what problems the district board members have
encountered. The approach here is one of triangulation
whereby both qualitative and quantitative research

methodologies are employed.

Sections Three and Four present the unit of analysis and the sampling used for the interviews, which are the main part of the investigation. Here, the district health boards served as the site for investigation. The members of two district boards in Southwest Saskatchewan were interviewed in the summer of 1998. Section Five presents the specific methods for data collection used for this study. The first method involved a perusal of relevant documents and legislation authored by the provincial government in order to get a sense of the processes involved in Saskatchewan's health care regionalization. The second method includes two sources of secondary data, which are intended to both supplement the interview data, and provide a source of validity. The third method is a face-to-face interview with the members from two Saskatchewan district boards. The interview itself is comprised of both close-ended and open-ended questions. The latter set of questions allows for a degree of exploration into the implementation of regionalization in the areas.

Section Six presents the conceptual framework for the analysis of the data. Here, the three aspects to the institutional change: participation, local elections, and devolution, are more specifically operationalized.

Section Seven describes how the qualitative and quantitative data are analyzed. The qualitative data are analyzed using a thematic content analysis. The quantitative data from the interview are analyzed using descriptive statistics. More specifically, the data is presented using frequency distributions. The secondary data is also presented through the frequency distribution format.

Section Eight describes the specific issues with validity pertaining to this study. Section Nine describes the steps taken to ensure an ethical investigation.

4.1 The Conceptualization of Democracy

The overall theoretical precept is that regionalization is a substantive realization of institutional change that is conducive to democratization. Here, the theoretical argument is that the current plan of regionalization in Saskatchewan's health care sector serves as a case study for the democratization of public institutions.

The current program of health care regionalization in Saskatchewan is in its early stages. The regional health boards were formed 1993, and the first elections for the health boards were held in the fall of 1995. The

interviews conducted for this study were undertaken in the summer of 1998, five years after regionalization.

However, the present study is intended to provide a base line for future research on the democratization of public institutions. In this respect, the present study is premised on the inference that the institutional changes to the health care system in Saskatchewan could have important consequences for democratization.

Using the three changes to procedure as a mechanism for investigation, this study is intended to answer the following research question: "Do the district health boards serve as the institutional site for the democratization of health care services at the community level?" Encompassed within regionalization are the institutional changes of local elections and the devolution of control as well as the emphasis on community participation.

The literature suggests that there is some potential for democratization, even if the changes are couched within political conditions, such as the possible domination of decision-making by professionals or the reality of political apathy. Having said that, I would hypothesize that regionalization, as a form of institutional change, will democratize health care decision-making.

4.2 Research Design

This investigation is primarily descriptive in nature. Descriptive research, according to Neumann, "... presents a picture of the specific details of a situation"[1]. Since there is existing information about health care regionalization in different contexts, this study was intended to study how it has been implemented in Saskatchewan, what possibilities it has for democratization, and what problems need to be addressed. The research is not intended, for instance, to answer the question of why regionalization has been implemented, but rather, to provide a mental picture of the processes and procedures that were involved. It is hoped by the researcher that this will contribute to the debates over how participatory democracy can be institutionalized.

The description of regionalization is gathered through a triangulated approach, which means a combination of "... different methodologies to overcome specific weaknesses in specific techniques"[2]. Thus, the research design incorporates both qualitative and quantitative approaches by using secondary statistical evidence and an in-depth interview.

4.3 Unit of Analysis

The unit of analysis for this investigation is the district health board since it is the embodiment of the institutional change. There were 31 health districts operating within Saskatchewan at the time of the interviews. Yet, because of time and monetary constraints, it was not feasible to study all 31 districts. Therefore, two districts were selected as study sites. The use of two sites for the investigation will enhance the study's replication and generalize the results[3].

The two sites were identified because of the ease of travel for the interviewer, and the location of these districts within the PECOS study area. The PECOS region itself encompasses the Palliser Triangle in southwestern Saskatchewan. The population of this region is approximately 30 000 - half of which reside in Swift Current[4]. It is economically driven by agriculture - in 1996, for instance, there were 2775 farms in the PECOS region, 70% of which are used to raise crops[5].

Both regional boards have regional hospitals and at least 70% of the population in the regions are within 30 minutes of hospital services. Both populations have access to emergency care, and specialized care such as urology and psychiatry[6]. Moreover, both regions have

community care services, which provide access to basic
medical services, community services such as home care,
mental health counseling, therapies and public health,
emergency and stabilization services, convalescent care,
respite care, palliative care and day/night care[7]. The
populations within both regions also have access to
nursing homes, long-term care and adult day care as well
as home care services[a].

Moreover, the two sites represent different degrees
of decentralization. For one district, many of the
health resources are more centralized, making access
easier for the people in the region. The other district
is denser in population, making it possible to ascertain
any differences with regards to access.

One important aspect of the populations of
southwest Saskatchewan that needs to be considered is
the average age of the population. The population in the
area tends to be, on average, older than the
Saskatchewan population. For instance, the health
regions under investigation have a higher number of
people aged 65 and over than the general population of
Saskatchewan, which creates certain considerations for
policy development in health care (i.e. the need for
palliative care and long-term care facilities). Another
important consideration here is the unrepresentativeness

of the regions with regards to ethnic composition[3]. For instance, the southwest region has fewer people of First Nations descent compared to the overall population of Saskatchewan, thus changing the dynamics of health care initiatives (e.g. prenatal care).

4.4 Sampling

The members of the district health boards comprise the population of respondents since they were able to provide me with the background of their district and what factors influence their decision-making. A letter of introduction about the study was sent to both regional boards in the winter of 1998. Each group collectively responded through a representative (e.g. the CEO) that they were interested. The summer was selected as a time for the interviews because of the fact that some of the respondents were farmers and thus could not be interviewed during seeding and harvesting. The summer, however, made it difficult to reach some respondents due to holiday schedules.

The potential population size within the two districts was 24 (12 board members from each district board). Twenty board members were interviewed. At the time of the interview, one district was in a state of transition and had one vacant spot on the board. There

were two refusals and one potential respondent was
unavailable at the time of the interviewing stage.

4.5 Data Collection

The present study thus includes the documentation
of relevant provincial archives, the use of secondary
quantitative research data, and face-to-face interviews.
Moreover, there is an implicit flow in the research
design. The interview, for instance, was created after
an extensive review of provincial documents and relevant
secondary research.

4.5.1 Documentation

The first stage in the research design involved the
collection and analysis of provincial documents in order
to investigate the reasoning behind regionalization, and
how it has been institutionalized. One such line of
investigation involved the compilation of provincial
legislation that details the legal responsibilities of
the institutional boards and district health boards.

4.5.2 Secondary Sources

The interview data are supplemented by secondary
quantitative data conducted by other researchers in the
area of health care democratization. The first such data
is provided by a telephone interview which was conducted
by the PECOS research team in the summer of 1995. One
thousand community residents in Southwestern

Saskatchewan were interviewed on their perceptions of
ecosystem and community sustainability within their
area. One segment of this interview focused on the
connections between community sustainability,
democratization and health care reform. The data from
this study, therefore, supplements the present interview
since it reveals the attitudes of the community members
within the same geographical region about the impact of
health reform in Saskatchewan.

Another source of secondary quantitative data on
the connections between democratization and health care
reform in Saskatchewan is provided by the HEALNet
(Health Evidence Application and Linkage Network)
research team at the University of Saskatchewan. The
overall mandate of HEALNet is to explore how decision-
making is manifested within health care with the goal of
improving the nature of decision-making and information
use. Its primary focus of the Saskatchewan team is on
regional health care planning and the processes of
decision-making. The questionnaire results are included
in the 1998 document: *Regionalization at Age Five: Views
of Saskatchewan Health Care Decision-Makers*[10].

The study conducted by HEALNet in 1997 surveyed,
through a mailed-in questionnaire, Saskatchewan board
members (n=275), district managers (n=150), and

Saskatchewan Health Managers (n=100)on their views about regionalization and its impact on district health board decision-making. While there are several components to this study that are related to board decision-making, there are certain questions that are of particular importance to the possibility of democratization.

One section, for instance, asks the respondents about the activities and role of the district health board in relation to other groups (including district residents, management, and health care providers). In this section are questions regarding responsiveness, community participation, and the principle of inclusion. Another important section relates to health reform and regionalization that includes questions on accountability, and devolution. The responses of the health board members to these important issues provide quantitative data on the various democratic consequences of regionalization.

4.5.3 Interview

The primary data comes from face-to-face interviews with district health board members. As was previously stated, this method allows for more of an in-depth analysis of the inner workings of the district health board and their perceptions of regionalization. Thus, the interview itself is a process, which was created by

a perusal of the literature, the documentation stage, and the secondary data. The interviewing schedule was first pre-tested with an unrelated district health board. Comments from this pre-testing stage were incorporated into the decision-making over the interview schedule.

The qualitative data is derived from the open-ended questions on the face-to-face interview. The open-ended questions were utilized to provide a more in-depth investigation into the processes of democratization. They were also employed due to the small sampling size and to supplement quantitative data derived from the secondary sources.

Moreover, while there are some pre-determined questions and indeed, codification schemes, the analysis was more flexible in the development of the new concepts and codes. Indeed, the data analysis was flexible in that any themes that emerged in the interview were included in the codification scheme; they were not necessarily confined to the actual question.

The source of the quantitative data is the closed-ended questions asked in the interview and the statistics provided by the secondary sources. For the closed-ended questions, the respondents were asked a series of questions that asked them to rate their

responses (e.g. for the obstacles to community participation) or asked them if they perceived there to be any change to democratic processes (e.g. the responsiveness of the decision-makers) due to regionalization.

The interview itself, therefore, is partly focused, since there are predetermined themes that direct the line of questioning [See Appendix A]. The open-ended questions do allow for a degree of in-depth exploration. Some questions, such as the mechanisms put in place for community participation, are intentionally exploratory since little information exists about the means by which community members participate. Moreover, as this study aimed to understand the processes of democratization, the responses to the questions were probed to clarify their responses and to ascertain details about their responses.

4.6 Conceptual Framework

There are three major changes to health care governance in Saskatchewan under the program of regionalization. Regionalization in Saskatchewan has meant the devolution of health care service provision and resource allocation to the local level. Another change unique to Saskatchewan is the institutionalization of local elections in which

approximately two thirds of the board members are elected representatives of the local population. Finally, another element of institutional change implicit within the reform process is the implementation of formal and informal mechanisms and opportunities for community participation in health care decisions.

4.6.1 Devolution

First of all, the interview is structured to gather information about the past institutional boards - here defined as membership on the hospital, ambulatory and single care home boards. Five of the twenty respondents stated that they were members of ambulatory, hospital or single care home boards before the 1993 reform and thus provided information about how the health care system was structured in the past.

The structure of power relations between the institutional boards (e.g. hospital and single care home boards) and the provincial government was first investigated. To do this, the board members were asked if they were ever a member of a hospital, ambulatory or single care home board (Question A4:a). If the answer was yes, they were then asked how long they were members of the boards (Question A4b). Questions A5 and A6 are related to the role of the institutional boards and

provincial government in the decision-making process in the past health care structure.

Any responses related to the arrangement of current governance were next elaborated upon. The respondents were asked in Question B1 if they felt that regionalization had led to either an increase or decrease of local control over health care service planning and delivery or if they felt that local control has remained the same. They were then asked how it had increase/decreased (B1a, B1b) or how it has remained the same (B1c). In Question B12 the respondents were asked if there are times that they as a board felt constrained by the provincial government. If the response was affirmative, they were asked to give an example.

The location of the decision-making closer to the people has the possible consequence of being more responsive to the health care needs of the local population. Question B2 referred to the responsiveness of the localized boards; indeed, the board members were asked "Do you feel that the reform has made the health care system more responsive to local needs, less responsive or has it remained the same?"

4.6.2 Local Elections

A second component to the institutional change implemented in Saskatchewan is the use of local

elections for the selection of two thirds of the board
members. The remaining board members are appointed by
the provincial government to ensure that the board
membership represents all the necessary skills or
expertise, and represented minority groups. The use of
elected boards, though supplemented as they are by
provincial appointees has two possible outcomes: the
boards would be more representative of the local
population; and, the local boards would be more
accountable to the local population. In Question B3, the
respondents are asked if they perceive regionalization
to have enhanced the representation of the decision-
makers. The respondents are then asked if they think the
reform has made the decision-makers more, or less,
accountable to the local population in Question B4.

4.6.3 Participation

In 1993, the provincial government set out to
amalgamate the institutional boards into 31 district
health boards. The explicit intent of the provincial
government was to ensure that communities were
instrumental in the creation of the districts. The
community members themselves were asked to form the
boundaries of the districts, and each community had the
choice to join the district which best suited them.
Thus, the board members are asked if they were involved

in the creation of the boundaries (Question A3). Two respondents stated that they were involved and thus provided information on how the boundaries were formed in their district.

Another component to community participation is the identification of the means by which community members become involved in the regional governance. The intent here is therefore to understand the nature of community participation: how it is being realized and what obstacles prevent its full expression. There are many dimensions to this. First of all, an archival review of the board literature is employed to identify the mechanisms by which the district health boards communicate with their community members (e.g. Internet addresses, publications, etc.).

Secondly, the respondents are asked in Question B6: "How do community members participate in board decision-making?" The classification scheme is not created beforehand since the question is intended to be primarily exploratory. The codes were thus developed after the responses were perused. The respondents are also asked how they think that the community should become involved in local board government since this would be important in facilitating participation in the future. Again, the codes were not pre-set.

Another important component to the success of
community participation is the identification of
intervening variables with regards to effective
participation. More specifically, Question B9 is
formulated to identify the extent to which the following
are obstacles to community participation: a lack of
time[11]; citizen apathy[12]; lack of citizen knowledge[13]; and
access to the board office due to geographical distance.
The respondent was then probed about his or her response
- for instance, why it was an obstacle (Question B9:a).

The quality of community participation is another
important issue. If the participation is merely
reactive, then there are questions about how well
community members are incorporated into the decision-
making. Thus, the respondents are asked if they thought
that the participation by the community members is more
reactive or proactive in nature (Question B8). They are
asked to elaborate on their answers.

The issue of which factors influenced board
decision-making is also explored. First of all, the
board members are asked if they are influenced more by
community knowledge or expert knowledge[14]. Question B11,
for instance, asks the question: "Which has more
relevance to your board's decision-making - community

knowledge or expert knowledge (e.g. health professionals, bureaucrats, academics?)".

The concept of community participation does not just include how people become involved, but rather, whose voices are credible to the board members. At issue here is if the board decision-making reflects all the people affected by the decision-making[15]. The respondents are asked if they felt that board decision-making is inclusive of all the members of the community (Question B10). If they stated that it is inclusive, they are asked how (Question B10a). If they stated that it is not inclusive, then they are asked how it is not inclusive (Question B10b).

The board members are also asked about what groups influenced their decision-making and how this influence is manifested (Question B5). Here, several sectors are identified: Saskatchewan Health; interest groups; service providers, and community members. If the responses are positive, the respondents are asked how the groups influence board decision-making. If the response reflected that the group did not influence them, the respondents are probed as to why.

4.7 Data Analysis

The data obtained through the interviews is analyzed through both a thematic content analysis and

through descriptive statistics. The data was categorized

through preset themes and codes. However, there were

some instances where themes emerged after the data was

perused several times; therefore, some of the codes were

developed after reading through the responses.

The thematic content analysis was not set

quantitatively, that is, the responses to the open-ended

questions were not quantified. The emphasis for the

responses was mainly predicated on a more analytic

approach that included making a matrix of categories and

placing the evidence obtained within such categories[15].

Indeed, the interview data is analyzed and presented

through a description of events. It is thereby

interpreted by finding out how the district health board

members view regionalization and how it is being

implemented. Their responses provide data for an

inferential model of democratization.

A majority of the interviews were taped and were

later transcribed onto Microsoft Word. Some respondents

did not consent to being taped; thus, their responses

were noted in writing and later transcribed. The

interviews took place both in the board office, and,

especially for rural board members, in the respondent's

home or place of employment. Care was taken to ensure a

freedom from distraction.

The qualitative data from the open-ended questions were transcribed into the ETHNOGRAPH v4.0 software package and was sorted an analytic codified scheme which allows for greater flexibility since some themes appeared after the interview data was perused. The coding scheme is presented in Appendix B.

The closed-ended questions from the interviews are summarized using simple univariate frequency distributions. Moreover, the quantitative data from the secondary sources is also presented using frequency distributions.

4.8 Validity

The idea of democratization could have different meanings to different subsets of the population. The community members, for instance, would have a different perspective about democratization in their particular health district. They remain, therefore, an important component to the study. Their perspectives are represented, to some extent, within this study through the use of the 1994 PECOS telephone survey. The responses of the community members are thus investigated in order to perceive any differences or similarities between them and the board members.

The board members were chosen for the main interviewing schedule because they are the ones who

would have first hand experience with the extent of democratization in their district. The board members, for instance, are the ones who, through policy directives, make the choices about the implementation of participation in their region, can provide the implications of having local elections, or who have first hand experience with the devolution of control. Utilizing community members may only ascertain impressions of democratization.

The selection of the units of analysis, however, poses some degree of difficulty with regards to external validity. At issue here, however, is how reflective their responses are to other districts in Saskatchewan, especially the northern regions of Saskatchewan (which has a larger First Nations population) or the larger urban centres. A very small percentage of the population within both districts is of First Nations ancestry. Moreover, there are very few visible minorities in the region compared to the rest of Saskatchewan[17]. Therefore, further studies in different district sites should be explored to enhance generalizability[18].

There were several steps taken to better ensure internal validity. First of all, the research design incorporates several data collection mechanisms - the documentation of relevant sources, the utilization of

secondary quantitative data, and an interview of the board members[19]. Moreover, preliminary testing was done twice with a member of the Saskatoon District health board in order to ascertain the validity of the interview schedule. Finally, the results were sent back in the winter of 2001 to the board members to ensure that the interpretations were accurate. All of the board members who were contacted for this study were still board members when the information was sent to them for verification. The boards were contacted and it was affirmed that the results accurately portrayed their opinions in 1998.

4.9. Ethics

This study was conducted using the principle of informed consent. Informed consent means that the subjects are aware of their rights and about the study in its totality. Neuman offers this typology for the informed consent requirement that were emphasized in the present study:

1. A brief description of the purpose and procedure of the research, including the expected duration of the study.
2. A statement of any risks or discomfort associated with participation.
3. A guarantee of anonymity and confidentiality.
4. The identification of the researcher and of where to receive information about subjects' rights or questions about the study.
5. A statement that participation is strictly voluntary and can be terminated at any time without penalty.

6. A statement of any benefits or compensation provided to the subject.
7. An offer to provide a summary of the results[20].

The University of Saskatchewan approved an application for the approval of research protocol in the winter of 1998 [see Appendix C]. In the summer of 1998, the letters of consent were sent to each district board office [see Appendix D] where they were disseminated at the board meeting. Each board member was asked to return the letters of consent through mail or at the time of the interview. Before the interview, the board members were informed that they could refuse to answer any questions without explanation. They were also asked if they had any questions at all about the research - what it would be used for, why it was being conducted. Each respondent was verbally informed that the researcher would keep their names confidential and would do whatever possible to ensure that they or their health district were not identifiable. To that end, pseudonyms for communities were used to further ensure confidentiality.

Notes

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[2] *Ibid.* p. 336.

[3] R. Yin (1989). *Case Study Research: Design and Methods*. Newbury Park: Sage Publications.

[4] http://www.cprc.uregina.ca/pecos/poster/Area.html Accessed July, 2001

[5] *Ibid*

[6] http://www.health.gov.sk.ca/ph_map_list.html Accessed July, 2001

[7] *Ibid*

[8] *Ibid*

[9] The patterns here are taken from the Community Profiles database from Statistics Canada. http://ww2.statcan.ca/english/profil/ Accessed July, 2001

[10] D. Kouri, J. Dutchak, and S. Lewis (1998). *Regionalization at Age Five: Views of Saskatchewan Health Care Decision-Makers*. Health Evidence Application and Linkage Network: Saskatoon.

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[14] See, for instance, K. Graham & S. Philips (1998).

[15] See, for instance, Saskatchewan Health (1993). *Planning Guide for Saskatchewan Health Districts: Part I: Strategic Planning*.

[16] M.B. Miles & A. Huberman (1984). *Analyzing Qualitative Data: A Source Book for New Methods*. Beverly Hills, CA: Sage.

[17] http://ww2.statcan.ca/english/profil/Accessed July, 2001.

[18] R. Yin (1989).

[19] *Ibid.*

[20] W. Neuman (1997).

5.DATA ANALYSIS

Chapter Five contextualizes the data from the
interviews and secondary sources within an analysis of
regionalization in Saskatchewan. Section One describes
Saskatchewan's past and present programs of
regionalization. The data analysis is broken in Sections
Two, Three and Four into the three changes to the
administration of health care in Saskatchewan. Section
Two, for instance, looks at how devolution is both
formally institutionalized in Saskatchewan's health care
system and, how the members describe its realistic
implementation. Although local control is a reality
within Saskatchewan's health care system, certain issues
need to be addressed – for instance, the possibility of
political manipulation or citizen apathy.

Section Three begins with an analysis of
Saskatchewan's use of local elections and if this has
increased the accountability of formal decision-makers
to the ordinary individual. It also has certain
ramifications for political representation. The results
show that, according to the board members,

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regionalization, with its use of local elections, has made the decision-makers accountable to, and representative of, the local people.

Section Four looks more specifically at the possibility of local participation in the development of health policy. The conclusions reached here is that the health boards do have the potential to form a public sphere since avenues for community participation are available. Moreover, there is evidence that board members place some value on the contributions of community members and their knowledge. There are some issues that need to be addressed, however, before any claim to full participation can be made. First of all, having a participatory structure in place does not necessarily lead to community participation. A lack of community involvement and inadequate knowledge about the health boards and complex health care issues are noted as obstacles to community participation[i]. Participation, in the words of one board member, has been: "minimal".

5.1 Health Care Regionalization in Saskatchewan

Health reform in Saskatchewan is rooted within a unique social location that has historically fostered the concept of "the collective good". The move towards state intervention in health care provision and services

was marked, for instance, by intense debates between various social groups, namely the Canadian Commonwealth Federation with its constituent base of farmers and unions, and private interest groups such as physicians and private insurance corporations[2]. Indeed, the ability of citizens to have an impact on the structure of health care is part of the history of Medicare itself.

But more, Medicare was first conceptualized as a regional system. Initially 13 regional boards were formed under the Health Services Act. They had the mandate to supervise the region's health services, including the maintenance of buildings, the development of regulations, the arrangement of polls and the provision of medical care[3].

In the end, however, Saskatchewan's regionalized system was fraught with the same problems that have been noted in other experiments with regionalization. The boards, composed of "laypeople" could not sufficiently challenge the medical establishment who were vehemently opposed to "socialized medicine". Moreover, while initially the regions were given a great deal of control over the administration of health care services, this control was eventually eroded until the regions served in advisory capacities only. For instance, by 1984, the

issues of staffing, budgeting and resource allocated
were centralized, giving the regional boards little
actual local control[4]. Management of the health programs
was controlled locally by the various hospital, home
care and hospital boards.

Yet the principles of regionalization did not
disappear. Indeed, since 1993, thirty-two district
health boards have been formed in Saskatchewan under the
rubric of reducing the duplication of services,
integrating services, and inviting public involvement in
the decision-making. Unlike the old regional system that
was developed in the forties, however, the role of the
regions is not to simply advise - they have considerable
control over health care service planning and delivery.
Indeed, while the province ultimately still retains
control over the purse strings, the district boards have
discretion over the allocation of resources for their
own district. Another important component in the
regionalized program is the institutionalization of
public elections, making the district decision-makers
more accountable to, and representative of, the local
population.

The decision to revitalize a regional program did
not take place overnight. Over the decades, the

devolution of power to local people still remained
within the literature. In one document entitled *Consumer
Participation, Regulation of the Professions and the
Decentralization of Health Services*, the regional
structure is held to be more accessible and responsive
to the needs of citizens. Moreover, it provides a more
workable structure for "direct involvement and
participation of individuals"[5] since the people would
have a closer proximity to the governors. The
connections are thus made:

> If it is granted that there is a growing need for
> increased popular and consumer participation in
> the determination of public services, particular
> decentralized mechanisms are required for the
> activation and involvement of the people toward
> the goal of self-help and the relatively small
> region is more likely to accomplish this than is
> the central mechanism of the provincial
> government or department[6].

But more, the district board members, since they are
themselves local community members, would be more
informed about the unique community preferences and
cultural expectations. Decisions would thus incorporate
the needs of the community members, rather than just
being made by bureaucratic fiat.

The promise here is for a governance structure that
is able to incorporate community needs into sound fiscal
policy. The best solution to the woes of rising health

care expenditures is to increase consumer and community
control over the direction of health care service
planning and delivery. Indeed, district board members
would make more rational decisions than the Union
Hospital districts and hospital boards about bed use,
thus avoiding a duplication of services within an area.
Moreover, because of their proximity to the local
population, and their knowledge of the true needs of the
local people, district boards would be able to make more
cost effective decisions about true health needs within
the area. A global budget would enable them to
disseminate resources where they are needed. Cost
control and community participation would be two likely
outcomes of regionalization.

Yet it was not until 1990 that these principles
reemerged within political discourse. In one document
Future Directions for Health Care in Saskatchewan, the
plan for a renewed version of regionalization was more
fully articulated. The system, the report argues, should
be more responsive to, and representative of, the local
population and should invite more public participation
in the decision-making process. The spirit behind this
was to ensure that decisions accurately reflect health
care needs, the utilization rates of services, and

demographics.

In 1991, the provincial government began
implementing action based on the principles of community
inclusion, service integration, and the effective
allocation of health resources. The plan for health
reform was detailed in the 1992 document: *New Directions
for Health Care* and later enacted through the *Health
Districts Act.* The reform as detailed *in New Directions
for Health Care* is premised on a community-based
wellness model of health delivery. Guided by the health
promotion literature, the new health scheme (or Wellness
Plan) is based on the shift from the costly, and often-
inefficient institution-based approach, to one based on
a model of community control. Here, the communities will
have more of a say over the distribution of health care
dollars and policy formation. In the words of then
Health Minister Simard:

> Our objective is to provide better quality care
> that's more affordable and therefore more
> sustainable in the long run. We want people to
> take more ownership of the health-care system,
> and more responsibility for their health'.

At the same time, the promise of the new health care
reform is that it will restructure the health system, so
that individual consumers and communities will have more
control over their health care services. This, according

to Simard, will lead to a "revitalization" of the
communities. It will be the beginning of new alliances
between communities, governments, health organizations,
health care providers and health consumers[8].

The *Wellness Plan* itself is based on the
paradigmatic shifts taking place within both how health
is defined, and how public services should be delivered.
It was stimulated by the changing definition of health
offered by the World Health Organization (WHO), which
goes beyond the biomedical model of health. For the WHO,
health is a "… state of complete physical, mental, and
social well-being and not merely the absence of disease
or infirmary"[3]. Moreover, health is conceptualized to
expand people's physical state to include lifestyle as
well as social and political factors. Thus, according to
the WHO: "health is seen as a resource for everyday
life, not the objective of living. Health is a positive
concept emphasizing social and personal resources, as
well as physical capacities"[10]. Thus, within the health
promotion paradigm, the determinants of health have been
expanded to include socio-political variables, such as
the impact of a stable ecosystem, peace, equality,
resource sustainability, education, income, and social
welfare on the health and well being of a population.

This means not merely relying on access to institutions, technology, and professional expertise as solely determining health or the absence of health[11].

The health promotion framework views health as a resource, the maximization of which is reached when "… individuals are able to attain a state of complete physical, emotional, and social well-being"[12]. Health is better reached when people are empowered to take control of their environments and their individual circumstances[13]. Three strategies for achieving this optimal state of health include: "(1) fostering public participation in the definition of health needs; (2) strengthening community health-services as the most appropriate means of achieving health; and (3) coordinating healthy public policy"[14]. The first two strategies have implications for democratization. First of all, they translate into a larger role for community participation in the definition of health care. In the 1986 *Epp Report,* community empowerment is the end-result of a health promotion mandate that allows for a greater role for community participation. Here, "communities will become more involved in planning their own services, and that the links between communities and their services and institutions will be strengthened"[15].

The objectives of Saskatchewan's *Wellness Plan* are thus premised on the potential empowerment of communities and individuals, and the relativity of the meaning of health. It encompasses a more flexible and situational definition of what health is and how it could be attained within each community. Indeed, the objectives of the plan are:

a) to improve health, in its broadest sense, of both individuals and society;
b) to increase community involvement and control over the health care system;
c) to improve the integration and coordination of health services;
d) to shift resources from institutional to more effective community-based health services;
e) to emphasize disease/accident prevention, healthier lifestyles, service effectiveness and healthier public policies;
f) to increase consumer input and control; and
g) to create a more client-centred, community-based, outcome-oriented health system[16].

In essence, this means a return to the community and an invitation for more control over health care resources by all the stakeholders affected, including patients, community members, and service providers.

The health care system in Saskatchewan, therefore, was reorganized to ensure greater coordination and integration through rationalization. One outcome of regionalization has been greater community control over health care decision-making. For instance, in 1993 the

Saskatchewan communities were able to choose which districts they wanted to join. That is, the communities themselves have formed the 32 districts. The size and number of the districts was based on the location of communities, population distribution, geographic barriers, trading and commuting patterns, location of current health facilities, and population health status[17]. The population range for the districts is from 9978 to 224 565[18]. What is interesting to note is that the district borders were not pre-set by the province. Instead, the community members themselves were responsible for the district formation, which accounts for the often-odd shapes of the district borders.

5.2 Devolution

The regionalization of health care required a paradoxical structure of both centralization and decentralization. Previously, the administration of institutions was controlled by hospital, ambulatory services and single care home and community boards. Indeed, the boards themselves were responsible for the day-to-day activities within their respective districts. For instance, the ambulatory boards directly operated, maintained and provided ambulance services for their district and were responsible for the hiring and firing

of personnel[19]. The home care boards were appointed by the local municipalities and were responsible for the administration of home care within their district[20].

The institutional boards were structured along a very clear line of authority. Indeed, the funding and administrative activities of these boards were directly controlled by the Department of Health through 'line by line' budgets[21]. That is, program development and resource allocation within the institutions were clearly defined by the provincial government, thus, "… flexibility to make program changes or to shift funds even within the program area was restricted"[22].

Section 16 of the *Health Districts Act* dissolved the union hospital, ambulatory boards and single care boards, replacing them with the new regional health boards. Indeed, the 133 hospital boards, 108 ambulance boards and 45 special care boards[23] have been amalgamated into 32 district health boards, mainly to avoid the duplication of services between hospitals and regions, and to go beyond the "inertia" and "parochialism" found within the fragmentation of governance[24]. The responsibilities for hospitals, ambulatory services and home care were subsumed under one local authority, displacing a great number of

community members. Ironically, it could be argued that the centralization of authority has served to further separate the citizenry from control over the health care system.

Yet while amalgamation did consolidate the institutional boards, the question remains whether they had any control over the direction of health care decision-making, or if they merely served the directives of the provincial department of health. The 1993 program of regionalization served to create new local responsibilities for health care, which include the development of policy as well as resource allocation. Within Saskatchewan, then, the district health boards are mandated with certain responsibilities over health care service planning and delivery. Thus, one structural change, which ensues from regionalization in Saskatchewan, is the devolution of control over resource allocation and service provision. For instance, in 1995, policy involving health services, and public health were transferred to the regional boards. The provincial government maintains control over the maintenance of universal standards, and the provision of tax dollars to the district boards. The provincial government also maintains a supportive role by assisting the boards, for

instance, with the needs assessments[25]. The roles and

responsibilities for the districts and the provincial

governments are developed through a service agreement.

More specifically, Section 26 of the *Health*

Districts Act outlines the services to be provided by

the district health boards:

26(1). A district health board may provide services, and
for that purpose may:
a) periodically assess the health needs of the persons
to whom the health district provides services;
b) prepare and maintain a plan for the provision of
services;
c) co-ordinate the services that it provides with the
services provided by other providers of services and
with other related activities;
d) promote and encourage health and wellness;
e) periodically evaluate the services that it provides;
f) co-operate with the Government of Canada and its
agencies, the Government of Saskatchewan and its
agencies, the governments of other provinces and
territories of Canada and their agencies, Indian
bands and any other persons for the purpose of
providing services;
a) subject to this Act and the regulations, make by-laws
and rules governing the activities and affairs of the
district health board;
b) subject to section 28, purchase, lease or otherwise
acquire real property;
c) subject to section 28, sell, lease or otherwise
dispose of real property when that real property is
no longer required or when the district health board
considers it desirable to do so;
d) purchase, lease or otherwise acquire personal
property;
e) sell, lease, or otherwise dispose of personal
property when that personal property is no longer
required or when the district health board considers
it desirable to do so;
f) accept grants, donations, gifts or bequests or real
or personal property;
g) subject to subsection (2), manage, invest and expend

all moneys and manage all property that belongs to
the district health board;
h) subject to section 28, construct, operate, and manage
facilities;
i) provide funding to other persons who provide
services; or subject to the approval of the minister
and to any regulations made for the purpose of this
clause, to any other person;
j) employ or engage the persons who provide services of
any person;
k) provide superannuation and other benefits for its
employees;
l) enter into agreements with the Government of Canada
or its agencies, the Government of Saskatchewan or
its agencies, the government of any other province or
territory of Canada or its agencies, any other
government organization, Indian bands, or any other
persons;
m) subject to regulations, determine the charges to be
made for services provided by the district health
board;
n) co-operate with persons who provide education or
training to students of disciplines, occupations, and
progressions that provide services;
o) appoint committees to provide advice to the district
health board;
p) exercise any other rights, powers and privileges that
are necessary, incidental or conducive to the
exercise of the powers conferred by this Act.

One important omission here is the provision of

physician services. Saskatchewan Health signed an

agreement with the Saskatchewan Medical Association

(SMA) and the Saskatchewan Association of Health

Organizations (SAHO), which ensured the professional

independence of physicians[26]. Physician services,

therefore, remain under the mandate of Saskatchewan

Health. Physicians in Saskatchewan, however, do have

access to the district health boards, and are eligible

to run for board positions[27].

Another important consideration for the boards is that while they have a great deal of control over health care service and delivery, there are certain constraints placed on their decision-making by the provincial government, particularly with regards to funding. Section 27(3) of the *Health Districts Act*, for instance, ensures that the district health board "conduct its activities and affairs in a manner consistent with and that reflects the health care policies, goals and priorities established by the minister".

One priority of importance here is the provincial government's commitment to community care. Since institutional care, such as long-term care, is costly, the provincial government has ensured that the health districts move from a model of institutional care to community care. This is achieved by implementing a one-way valve of funding, whereby the health boards can move money from institutional care to community care, but not the other way around[28].

5.2.1 The Structure of the Institutional Boards

The duties of the institutional boards involved the running of the institution, even to the minutest detail. One board member, for instance, commented that: "When I

was on the old hospital board, we made the decisions on small details. I can remember even ordering new food trays. Like here, we never would be". The boards, therefore, were responsible for, as **Respondent 109** states: "setting the budget" and "purchasing new equipment". In essence, the institutional board members were responsible for, as **Respondent 212** explained, the "capital, budget and operational" decisions for their particular facility. In sum, according to **Respondent 108**, policy was determined by the provincial government and the boards were responsible for carrying it out: "It was very much a bureaucracy the way it was set up. I mentioned earlier that we weren't doing more than just paying the bills. We weren't making any decisions about policy or anything that was going on in the hospitals".

This centralized system of control was cemented by the system of funding. In the past system, the institutional boards were given a line-by-line budget, which essentially mandated the centralization of decision-making. The provincial government had the ultimate control over institutional spending, making the local board members more responsible for carrying out the decisions rather than generating them. **Respondent**

203 states that by using the line-by-line funding

formula: "The government was more informed of what was

happening and was able to control and operate under

budget". Another respondent **(R108)** echoed this: "Before,

it was line-by-line funding that you got from the

department. And this meant that you spent so much money

on that and if you didn't, and the money went over to

some place else, then the department was quite adamant

that you didn't do that". One respondent further

suggested that the centralized decision-making led to

the "micro-managing" of the board's decision-making:

> **R212**: Like in a traditional line they get into the micro
> managing, so they could call a number of shots.
> Because it was small they could keep up with it.
> They would come in and ask questions about this area
> and that area... they also monitored the budgets
> quite closely and you know, the line-by-line. So
> they were still a part of it when you were to do
> something; they were still making the decisions.
> Like for instance, if we were going to put windows
> into the facility, then, we would put forth a
> proposal and they would make that decision. And now
> a lot of that is just done without that.

If the boards required additional funding, they

were able to go to the local municipalities who would

then supply the funding shortfall:

> **R109**: Well, they [Saskatchewan Health] were the
> principle funding (sic). They gave pretty well the
> whole budget. If you wanted anything extra, well,
> that's when you ran a deficit and the municipalities
> would pick up that deficit... Like what happens...
> the DOC, Directors of Care, says that it would be

> nice if we had another girl on the floor and she
> would look after the old people. Well that would
> be... we just went to the municipalities and said,
> "We need X number of dollars more" and budgeted for
> it. We requested the requisition for it. Which you
> don't have now. You cannot do that anymore.

According to **Respondent 108**, the boards were thus

accountable to both the provincial government and to the

local municipalities since they received funding from

both parties: "We were accountable to the municipal

council and certainly also to the department of health.

They had rules and regulations for, you know, certain

capital expenditures. You worked with the department and

with the municipal council, they were the ones raising

money for these expenditures".

However, the hospital boards had little by way of

autonomy from the provincial government. Indeed, the

decision-making process was primarily top-down. For

instance, one respondent states:

> **R108**: I guess that when I think back to the hospital
> boards, again, you had so little control that you
> had a tendency to say, well, it's out of our hands.
> We can't do anything different than what we're
> doing. We had to go by what the bureaucrats in
> Regina tell us, and didn't, couldn't really do a lot
> on our own.

Furthermore, the previous structure of governance,

according to the same respondent, was inefficient and

did not encourage cost control measures:

> **R108**: Well, certainly you were fairly limited as to what

decisions you could make. I guess that we pretty
much came to the conclusion that all we were doing
was paying the bills. We did have a certain degree
of autonomy, but if you were trying to run things
more efficiently and save some money, they just cut
your funding so there wasn't much incentive to do
that.

5.2.2 The Structure of the District Health Boards

After the 1993 reform of Saskatchewan health care

services, control over service provision and resource

allocation was devolved from the provincial government

to the district health boards. The provincial government

is responsible for setting up universal guidelines for

the district health boards and allocates the funding

from provincial taxes. The district health boards have

been given control over policy development, resource

allocation, and service provision. Each board is made up

of twelve members, of which four are appointed by the

provincial government and eight are elected. Each board

has a chairperson who guides the meetings and has

contact with the provincial government and the Chief

Executive Officer (CEO).

The structure of the district health boards is set

up under the Carver model of board management and

governance. The Carver model stipulates that the boards

are given the mandate to set the policies for their

district, including developing a mission statement,

setting the priorities for service allocation and targeting the service recipients[29]. As one board member **(R206)** states: "And also now, we're dealing with just policy and having reports coming in; we're not dealing with the management things that we were before, like the day-to-day management decisions".

The CEO, who is, in essence, the only employee of the board, undertakes the actual management of board policy. **Respondent 202** states: "We as a board have one employee that we tell what to do and that is our CEO". According to **Respondent 109**, the actual day-to-day administration of the district health board is the CEO's responsibility: "... once the policy is set out, then the CEO will implement them and carry them out".

More specifically, the CEO is set up structurally as the go-between for the board and the health care employees:

R206: He comes to us with all the knowledge about what is happening with the health care workers. You know, so he keeps us up to date with what's happening with the health care teams and what's happening with the staff.

The board therefore, does not have any contact with the employees; any complaints are filtered up to the board through the CEO. For instance, **Respondent 203** states:

"We receive complaints because they go through the CEO".

Another board member **(R202)** argues that the board

members have contact with physicians through the CEO:

"He deals with the physicians. We don't deal with the

physicians ourselves".

The "managers" also administer any contact with the

health care workers. Here, the board members argued that

they do not have much contact with the health care

workers; any information transfer is done through

administration, which keeps it more anonymous:

I: What about other health care workers?
R111: Well, I can only go by the reports that we get
    from the different directors that we have at our
    meetings. We set the policies and certain parameters
    to work within. It seems generally good. We don't
    hear the names, but you might hear that we've had
    three complaints with nurses and something and what
    the complaints are and things like that. You don't
    get into personalities or who its from. So I think
    that way, it's good because they feel free to...
    maybe complaints isn't the best word... to voice
    their concerns through the managers. And that is
    systematically reviewed.
                            ...
R201: Well that's difficult to say because we're not in
    touch with them a lot. But, I hope that we have the
    management in place that they can make their
    complaints, concerns to us. That is what is supposed
    to happen and I believe that we have policy that the
    managers put forward the issues to us in a timely
    fashion.

The CEO also acts as the point of contact with the

provincial government. He or she, therefore, will

usually serve as the point of information flow between

the province and the board members:

R209: You've got to remember that I'm just a board member; we have the chairperson and the CEO who are more directly involved with the provincial government. They are the ones who attend the meetings and so on, and they come back and bring that information with respect to those meetings and so on.

There is not a consensus among the board members

regarding the value of the Carver model. Some see it as

a positive model for governance since it clearly

demarcates the division of labour, making service

provision more effective:

R209: I think that they are management and that they are supposed to put the hand on the day-to-day activity within the district. Again, and I clearly believe that the board is for policy and management is for procedure and staff is for production. That is sort of the three P's.
...
R212: I prefer the government's model today as opposed to then. It does allow the managers to manage and the board to monitor and make all the decisions that are needed to be made by the board.
I: Okay
R212: So I do prefer it this way as long as the board works within that reality and understands it.

For another member, someone who has the necessary

skills should do the management of the district's

services:

R202: There are times when I would like to jump in and be a manager, but I know that that wouldn't work. No one on our board has the expertise to do that. So ya, I think that it is very effective.

5.2.3 Local Control

One explicit intention of the 1993 reform was to devolve control to the community level. There is some indication that it has happened. In a 1997 study on regionalization conducted by HEAL*Net*, Saskatchewan board members were asked if local control had increased, decreased or remained the same due to the reform[30]. Here, 63% of the board members stated that there was an increase in local control over the health care services[31]. A significant minority, however, argued that local control had remained the same (13%) or had decreased (24%)[32]. Roughly the same number of board members did not foresee any increase in the future; only 67% of the board members saw any possible increase[33].

In the telephone study by PECOS in 1995, community members in the southwest corner of Saskatchewan were less optimistic about the efficacy of regionalization in increasing local control over health care services. Here only 31% of the community members agreed that local control would be enhanced, 27% were neutral and 43% disagreed[34].

The board members from the health boards were also less optimistic about the impact of the reform on localizing control. Indeed, less than half of the board

members interviewed for this study (45%) stated that

regionalization has led to an increase in the local

control of health care services and 20% argued that

local control has remained the same, while over one

third (35%) stated that local control has decreased

[Table 1].

Table 1: The Impact of Regionalization on Local Control[a]

Question	Response and Percentage Score		
	Increase	Decrease	Remained the Same
Do you feel that regionalization has led to an increase or a decrease of local control over health care service planning and delivery, or do you feel that local control has remained the same?	45	35	20

[a] Sample size N=20

Indeed, devolution has been preset through a

provincial framework. Some board members stated that the

flow of control was strictly top-down.

R201: No. Because they are - the health boards are a
front for the provincial position. Just rubber-
stampers… We do have a lot of power, but there is a
lot of pressure from the provincial government to do
things their way. The provincial government has a
grand scheme all worked out... I think that they're
[provincial government] onto something good. But
they're afraid to give up some of their power. It's
difficult for them.

. . .

R103: Well, you have to do exactly as they [provincial government] say, so I guess you have no choice. Your choices are very limited.

. . .

R205: The government still has a tremendous amount of control. If we want to implement different things, we have to get government approval.

. . .

R107: I think in some cases we make good decisions, and sometimes we make better, but we're very limited in our decision-making by the provincial government, so... I mean in the structure and all that. I mean, they still have quite a bit of control over how we set up our programs even and how we spend our money.

Other board members, however, that argued that there was a certain degree of localized control, but that there were restrictions on their decision-making. As **Respondent 210** states: "Within certain parameters, yes, you've got free rein pretty much to do a lot more decision-making than before". Other board members, for instance, **Respondent 108**, reiterate this: "Oh, there's still a large degree of that, but I think... a lot of the decision-making has been passed down to the local level".

While the board members do state that control over the decision-making has been localized, the provincial government ultimately remains in control over the decision-making: "I think they have, it has increased somewhat in terms of local control but I still feel that

the government still has a lot of control".

The board members, therefore, argue that there is a certain degree of constraint placed on their decision-making by the provincial government. When the board members were asked if they have ever been constrained by the provincial government, 95% responded with a yes [Table 2].

Table 2: The Issue of Centralized Control[a]

Question	Response and Percentage Score	
	Yes	No
Has your board ever been constrained by the provincial government?	95	5

[a] Sample size N=20

The issue of centralized control is further reflected in the following responses:

R210: Oh, my goodness. Well, if it doesn't pass, if they don't salute when you raise up the flag pole, it doesn't fly... they really do have final say on whatever major issues, budgetary, service-wise, they influence the direction of health care they want the district to take. They sort of, not that it's wasted on you, but that they push that particular thing on you if they want, if they would like the district to pursue a certain model of health care, they make sure that they have their people from Sask. Health out, speaking on boards, if you were doing something with funding, they yank your chain, you have to adjust your budget to accommodate that. We're recently going through something where the board set management the task of coming to a balanced budget, it required hard-nosed decisions, there could possibly be some very serious cuts to services, the government representatives came along and very strongly

influenced the meeting ... the bottom line is the
government would not like to see services cut - "so
district, you are to do something different". So, if
they say jump, I think the district will say how high
...

R210: Again, I think the latitude we've been given, the
kinds of decisions I see being made without any sort
of input or interference from Sask. Health are not the
big decisions. When push comes to shove, and you get
in the crunch, and it's, okay, let's talk about what
services we're going to offer, let's talk about what
direction we're going to go in 3 years, whether this
service, facility, building or whatever will be here
in 5 years time, you start, or at least I start to
feel that there's going to be a bit of an influence
from Sask Health here. And I can see it coming in
fall when we discuss the results of the needs
assessment, it will ... whatever comes out of it,
whatever we decide, if it does not meet with the
overall direction of the government, we probably won't
be allowed to go ahead with it. Even the plans for
the rejuvenation of the hospital which were submitted
to Sask. Health right before Christmas, word came back
a month ago, yes we've been approved for the project,
but Sask. Health is deciding which portions of the
project will go ahead first. Now if what we wanted,
and they want are the same ... they're pressuring in
many different ways, some of them subtle and small.
...

R110: Well, I think that there's been major attempts for
there to be more local control, but I still think
that when push comes to shove, it's Saskatchewan
Health that steers the ship. I mean, you know,
there's things that are built in that may keep it
that way, which I think is a good thing. I don't
think that I want local boards to have total
control, not when you have universal standards.
...

R207: If we make a decision and the province doesn't
like it, it isn't approved. It is politically
motivated.
...

R202: We can't just go ahead and wipe out one whole
service without clearing it with Saskatchewan Health
so in that respect they still have the final say on
those kinds of things.

The flow of authority therefore, is a modification of the top-down model. The district health authorities receive a block sum of money from the province and are able to utilize it for their district's needs. As **Respondent 108** states: "We have the ability to move a bit of money around with block funding... we are able to move the money around which we think for our district is best". Another board member reiterates this:

> **R109:** Like, okay, I've been telling you about, we have to spend "x" amount of dollars in acute care. We cannot spend any more than what the government says we can. But other than that, we have a fairly free rein on where we spend our dollars. We can share it up and offer new services here, and if that service isn't doing well, we can take away from it. We can move our money around. We have a budget and we have to stay within it the best we can, but yes we can ... we're autonomous; we can move our money around and do those things.

However, the board members do operate within a certain budgetary framework since they are unable to levy taxes to pay for local services. When asked more specifically about how the provincial government retains control, there was often a mention made of the control over funding:

> **R103:** I suppose it would be if Sask Health could get their... get themselves in order and stop meddling.
> **I:** How do they meddle?
> **R103:** Funding... We've completely lost our autonomy. We no longer have the power to levy. As far as funds are concerned, we're completely under the whim of Saskatchewan Health.
> **I:** How are you under their whim?

R103: They ask you to put a budget forward. You put a budget forward and they may or may not fund it completely.

   ...

R205: The government still tells you how much you can spend and in what areas; like home care has to have a certain percentage.

   ...

R210: All decisions come down to that and the government still holds fairly tightly to the purse strings.

   ...

I: How has your board been constrained?

R202: Just a lack of dollars. There is only so much you can do with the dollars that they give you, so whoever holds the purse strings has the say.

   ...

R211: The provincial government still holds some power – especially with the allocation of funding.

   ...

R101: I guess there are a lot of ways... we have room to move in certain ways but there is a lot of ways that are beyond what we can do. And I guess by virtue of the fact that our funding comes from the province... that would limit us in what we can do... Well I guess that democratic means that I would equate it with the decision-making process. And I guess because of that I am saying that yes we have control of a lot of decisions, but in others we are very limited because of funding shortfalls or because of particular rules. There are restrictions at the provincial level as to the use of funds or whatever.

   ...

R108: It's one of those things where the guy who pays the piper pays the bill. That's a large part of the whole thing. The provincial government supplies the money and so they very much dictate in some areas as to what is going on.

More specifically, one board member from the more rural district argued that there is some control over the provision of certain services in the districts. The following example provided by this board member

exemplifies how the provincial government is able to control the direction of resource allocation within a region:

R110: There's things like if Sask. Health feels that there is an issue or something that needs to be addressed, then funding is directly transferred to the district for that particular program. For example, children with challenging behaviours moneys, money for the successful parenting support programs, things that are specifically told or dictated by the provincial government to the district and health board. So there's, you know, and they're not based on need, really — from the district's point of view. Some districts don't even have those issues. Like for example, successful parenting support program is built around the premise of having services to single, or to high-risk teens with children, right? Well, we have an incredibly low birth rate. We don't even have the population, so we've really been creative and still tried to stay within the mandate...

The respondent later makes the argument that, to some extent, the provincial government is affecting the programming choices of the region without first assessing need or consulting the district:

R110: When they implement programs ... oh, when they implement programs that are based on what they think the need is and people in the health districts aren't consulted about it, and then you're supposed to put a program together and there's really no clientele to fit that need, or very few. So it's a bit of a waste of money.

I: Can you give me an example of that?

R110: The Successful Parent Support program. They already know we have the lowest birth rate of anywhere in the province.

I: So what they did was they implemented this...

R110: They gave us money, they said, here is money. Go forth and put together programming for this group of people.

Moreover, one board member argued that the urban areas like Saskatoon and Regina are given more freedom with their funding allocation than the rural districts:

R101: To an extent, but we're still bound so terrible much by the money that we get that we have to make decisions that we don't want to and it seems that different boards have to stay more by the guidelines than others. Example, Regina, they were 6 million in the hole last time, or 3 million I'm sorry, and this year they're working on 6 million, whereas we're supposed to have a balanced budget, so where's the ... what's the word I'm trying to use ... the fairness, I guess, in that whole thing? Plus they don't give us enough money to ... every year, like, they give us x amount of money, but our costs go up, so of course we have, we end up in the hole more every year, so we have to cut a certain amount of services.

One important restriction placed on the board members is the one-way valve funding scheme whereby the board members may transfer funds from the institutions to community care but not vice versa:

R101: Well, I am going to give you an example and I am not negative about it. I think that there is nothing the matter with the rule but one example is that in the funding you cannot transfer dollars allocated for care to be provided in the community such as home care or the community of public health services. You cannot transfer community care dollars to institutional care. But you can transfer the acute care dollars to community care. I am not opposed to that rule but I am just using that as an example.
               ...
R108: Just by the fact that they control the money. I mean that's... and they can, they do have some restrictions built into money, into how it's spent. I mean you can't take money designated for community care facilities and put it into acute or long term care facilities. You can take money from the other two and put it into community care. You can't go the other way so they do have a degree of control there.

Finally, the board members expressed a concern over the provincial government's decisions to provide transitional funding after the board members have made the decisions over resource allocation. Often, the board members have had to make difficult decisions over staffing or service provision in order to ensure a more efficient system. The provincial government, they argue, then provides more funding to the boards in order to avoid making these cuts to services. This results, according to the board members, in a situation whereby their legitimacy is negatively affected:

R210: Again, the good old government will sometimes, I find, walk in and supersede all that, so ...

I: How do they do that?

R210: Well, at the last budgetary thing we just completed, management administration had identified some areas where they could do some cutting, where it was necessary to do some cutting. We simply aren't living within our means in this district. A government representative was present, listened to everything and then at the end said, gave a rather long song and dance, the gist of which was that they don't want us to do any of this cutting, whether it is simply being efficient. Even if some of the cuts were identified as things that should probably happen in the normal course of events anyway because it was duplication of services, or certain things are not necessary anymore due to automation and technology, we can therefore cut certain areas; it didn't go over well with the health representative. It seemed that the idea of any cuts at all was to be avoided, and he came through with an offer of transitional funding which the board found helpful, but it's very exasperating to have set your goals for management, set them a task of making hard cuts ... they come back to the table and say, here's where we're prepared to cut because you've mandated us

to trim "x" amount off the budget, and then the
government strides in like the knight on the white
horse saying, well, this is about the amount you guys
need to kind of stay afloat. Well this happens to be
about the amount of money we happen to have in the
kittie here, and we're going to give it to you as
transitional funding. Whew! We're saved! We don't have
to do any cuts. Well, there's a bit of frustration at
the board level. First of all, this additional funding
could not have been made known earlier? One, to save
both board and management the difficult task of trying
to decide where on an already thin staff you could
make cuts. This was even before I was on the board.
The issue was the elderly and the long-term care beds
several years ago, just when we moved here. All of a
sudden, well they needed money; they couldn't afford
the long-term care beds in a nutshell. They were
costing a lot of money. They needed the beds, but they
couldn't afford them. There's things going on there
behind the scenes that I'm not 100% sure of, but the
bottom line was the government suddenly came through
with extra money in the middle of the year, and lo and
behold the district has retained all of its long term
care beds as a result.

I: Have there ever been times when you've felt
constrained by the provincial government?

R210: Not exactly constrained — frustrated this most
recent round of the budgetary exercise, was my
probably firsthand experience with the sort of dance
that has to take place between Sask. Health and the
board. That's the main area where the board has to
sort of meet Sask. Health criteria and you know, come
up to snuff, and go back to the drawing board. They
pay the piper and they call the tunes ... and it did
cause considerable frustration.

...

R201: There's still a large provincial impact, no matter
what the provincial government is still in the
background. They inject money into the system for
different and specific things – every year this is
the same. The board sweats and worries and tries to
make the decision, then BOOM, the government gives
us the money.

...

R212: Okay. When the boards go out to make a decision, if
it hurts them politically they sort of work around it
so that decision really isn't valid anyway. Sometimes
I wish they would go ahead and make the decisions and

say here is the decision that we want you to make. And
that has happened in Riversdale on numerous occasions
now in the past two years. Where this has actually
been the case. Where the board has made decisions that
have hurt them politically, they want you to reverse
the decisions made. And there are no dollars there,
all of the sudden you have an objection and who is to
blame. You know they say, you have extra dollars now
why did you make that decision. So you are sort of
caught with them saying, we are providing you with all
the power and all the decision-making authority but I
don't see that it is...Well if the last objective
meets our needs. They have invested 5 million dollars
into hiring more nurses because the SUN put the
squeeze on them. The government caved in and it was
difficult for us to take a staff cut and then the
people come to us and say why do you have staff cuts
when you got a hundred and some thousand dollars added
into your budget. Like why would you do that? So the
government is actually undermining the board is what
they are doing. Like here is your budget, you have to
live within it, you have to make cuts if that is what
you need, you really watch what you are doing and this
comes through the Department of Health. You have to
really watch what you are doing and then they turn
around and say, oh guess what. We have just found
another $240,000 for you guys. So what are you doing
here, it is undermining, it is not allowing the boards
to do this sort of thing and it causes people to say,
like what are you doing as a board. Oh golly, guess
what, we have found another $400,000 transition money
for you. So they are constantly creating dollars and I
guess that my question to them was if you know that
you are going to give us an addition 6-700,000
dollars, give it to us at the beginning so that we can
properly appropriately plan. So it is very difficult
to plan because they are constantly undermining us,
doing things. Undermining the board's decision-making.

One board member argued that the issue of funding

was a site for the political manipulations of the

provincial government. At issue here, therefore is the

legitimacy of the health districts.

R207: Yes. We got special funding for maintaining

services - for instance the purchase of care homes, and $280 000 for RNs. That was pure political manipulation. The political goal was too obvious for me to swallow it.

But more, as the following board member argues, there is a certain degree of politics involved in the treatment of the rural and urban districts:

R103: Oh yes. In the cities, if you're from the city, the cities don't allow it.

I: Okay.

R103: It's ... I don't know how to describe it ... it was supposed to be, this new system was supposed to be non-political, but it still is. It's filthy rotten political. The cities, if they need money, they have a larger voice, they yell and holler and they get the money. We are the ones; we are sort of the have-not cousins I guess.

5.2.4 Responsiveness

Finally, when power and control over the decision-making is devolved to the local level, one expectation is that the local decision-makers will be more informed about the needs of the community members than centralized bureaucrats. Localizing health care decision-making therefore, ensures a more responsive system. In the HEALNet study, 80% of Saskatchewan board members agreed or strongly agreed that they are responsive to the wishes of district residents[35]. This finding is reflected by the interview data. Fifty percent of the respondents argued that the reform has made the decision-makers more responsive to the local

people and 40% stated that there is no difference
between the past system and the current one. Only 10%
argued that the reform has lessened the responsiveness
of the health care system [Table 3].

Table 3: The Impact of Regionalization on Responsive Government[a]

Question	Response and Percentage Score		
	More Responsive	Less Responsive	Remained the Same
Do you feel that the reform has made decision-makers system more responsive to local needs, less responsive or has there been no change?	50	10	40

[a] Sample size N=20

Implicit within the statements made is a connection
between localization and how well the boards can
understand the context of their communities:

R102: People in the district are in a better position to
do explaining and have a dialogue with the
community. Governments are too far removed. People
in the district are more grassroots and know what is
going on. What do Reginians know of what is going on
here?

...

R105: We have more say on what is being... well, on
programs and stuff for our area. We get feedback on
what is needed and then we make choices on what
programs to implement on that. Where a different...
you know... someone doing it somewhere else may not
know our area particularly.

...

I: Do you feel that the district health boards make
better decisions than the provincial government?

R206: I'd like to think so, because you're part of the community, therefore, you know better what the community wants.

> ...

R108: I think that we are making better decisions on some things, local issues. I think that you still need the department of Health, the provincial government, to get involved in setting the standards and all those types of things. I think certainly that the local board is more in tuned to community needs... And I guess the fact that we have to be accountable to the public makes it better. And not that the other politicians aren't, but they seem to be much farther removed than what we are and I think that that kind of accountability certainly leads to better planning.

> ...

R111: The provincial government is too far away from what's going on here. They're not into every district... they're more into Regina and Saskatoon I think than any of the rural districts.

There was also a feeling among the board members

that the boards were responsive to the local population:

R203: I think that we're more responsive.
I: How?
R203: Well because we've a lot more communication with the public... the public's more informed now I think in what's happening.

> ...

R107: More responsive.
I: And again, how is it more responsive?
R107: We make better decisions based on knowing our local needs.

> ...

R208: I think it is more responsive. I think that there is a larger accountability to local issues because the boards are set to represent local areas and the public is more demanding in a positive way.

Devolution means that authority for decision-making

is transferred to a local authority with only broad

principles being controlled by a centralized government,

and this is indeed reflected in the regionalization of health care in Saskatchewan. The province has certain responsibilities, which include setting universal standards and the allocation of block funding to the districts. The districts are then responsible for deciding how the money should be spent and setting the policy for their district. The clear boundaries between boards and province are necessary; a lack of guidance and procedure on the part of the provincial government could lead to a lack of uniformity in service provision and health outcomes in Saskatchewan. What needs to be addressed, however, is the very real possibility that the boards serve as the mere "mouthpiece" for provincial political agendas. There is evidence in the data that this is happening.

The evidence also shows a lack of faith in the realization of local control. Community members and board members are divided amongst themselves about the extent to which local control can or has been realized. Community members are the most pessimistic, perhaps reflecting a sense of alienation from the provincial government. This needs further development. First of all the PECOS survey was done in 1995, soon after the closure of hospitals in rural areas; therefore a more

recent exploration of community member's beliefs in regionalization is warranted since people's attitudes may have changed since 1995. Secondly, further exploration is needed because faith in local control may be a factor in not just the ability of people to become more involved, but in their belief that their involvement is meaningful.

5.3 Local Elections

Health care regionalization in Saskatchewan includes the local election of eight of the twelve health board members. Here, a ward system has been put in place: "to ensure residents have an opportunity to choose their local representative and to enable district health board members to have regular contact with their constituents"[36]. Each board member serves a four-year term, but the elections are staggered; elections are held every two years in alternating wards[37].

The remaining four members[38] of each board are appointed by the provincial government to ensure the representation of certain segments of the population. The possibility that the appointments may be made to ensure the representation of the existing political party in power also exists. The ideal here is that the board members, both elected and appointed reflect the

interests of the local people. Structurally, the
composition of the boards is inclusive. Indeed, anyone
over the age of 18, who is a Canadian citizen, has been
a resident of Saskatchewan for at least six months and
who is a resident of the region, is allowed to run for
membership on the board[39]. There are no restrictions
made according to occupation, gender, race, social
class, etc… Indeed, the health boards even stipulate
that health care providers can be elected or appointed
to the district boards.

5.3.1 Representation

One important issue with regards to the local
elections is the representation of the board members.
The majority of the members from both the boards (70%)
argued that regionalization has made the decision-makers
more representative [Table 4].

Table 4. The Representation of the District Board Members to the Community[a]

Question	Response and Percentage Score			
	More Representative	Less Representative	Remained the Same	Don't Know
In your opinion, has regionalization made the decision-makers more representative of the local population, less representative of the local population? Or has there been no change?	70	10	15	5

[a] Sample size N=20

The following responses reflect the notion that the

decision-makers are more representative of the

population since the reform:

R105: I think so because our board is scattered
   throughout the whole district, so I think that you
   can get a good opinion that way. And you divert the
   field of employment that way to.
                    . . .
R111: More representative of the local people? Well, we
   have nurses on board, and about three farmers, and a
   couple of businessmen. I think that's more
   reflective of our community.

Here, an explicit link is made between the use of

elections and representation:

R206: Yes, I think so. And why? The communities elect
   someone from within their ward, therefore the
   community knows that they have someone that they

themselves have elected and that they can go to them directly if they have any concerns. So you have a closer link. You're more accessible.

...

R208: It's an elective process. That in itself has to make it more representative of the people.

...

R201: The elections have allowed anyone to run for the board. That's pretty good.

...

R209: Certainly, there's a wide variance of background. With respect to whether they represent the community as a whole, I guess that would be somewhat questionable. But generally, because you have more people involved in the decision-making process, there is a wider range of representation.

R210: ... we're elected to represent the interests of the people in our particular areas.

The question of representation also brought out issues regarding political appointments and having health care professionals on the board. For instance, mention is made by the board members about the use of appointments for furthering the agendas of the government:

R210: I wouldn't necessarily say representative. Having elected board members is somewhat more democratic. No argument there. But what you get elected is not necessarily representative. A portion will be appointed, it's always a bone of contention as to what connection you have with the NDP, many jokes are made about it but I expect there's a certain degree of truth that you have to have the right connections to become an appointed member, and that's one-third of most of the boards right there.

...

R205: If you have 12 elected, you don't need 4 appointed people... You don't need that government monopoly of a quarter of the board...

I: Does this having their own agenda that causes the rift

in the board?

R205: Ya, because I think that my own personal opinion, I think that the people that are elected have more say of what's happening with the people, get more phone calls, and the ones that are appointed didn't have to go through that going and see people work hard to get on, they just write a letter and whatever the government decides is...

Another point of contention is the extension of

board membership to health care workers. There is

concern that the health care providers tend to direct

the decision-making to reflect professional concerns,

not necessarily community needs:

R210: The elected ones, the main problem is getting staff on the ... health care providers on board. And if you get a high number of those, or just simply a great vocal or active number, that kind of gears things. It may push the decision-making in a direction that's not necessarily good for the public at large, but may be good for say, the employees, the health care providers themselves. We have it to a small degree on our own board, that particular problem. There's just one or two voices, so it's not a major concern. I am aware of at least one other board in the province that I think has 6 or 7 people who are employees of the district, the health district, and that I think almost ties your hands. It doesn't make what your doing representative of the population at large necessarily.
      ...

R107: Well there are a few nurses and special care workers on the board and I think that that makes a big difference in our decision-making. Right down on the board it has made a big difference.
      ...

I: What kind of personal agendas?

R212: You have your employees sitting on the board and they do a lot to influence decisions. I believe that it is a strong conflict of interest. I would really like to see that in place. They cannot be truly objective and truly represent the people. And there again government - going back to another question - but the government recognises that health is the only

place where employees can run for a board. You can't
do it in education or any other place but in health
you can. And government does not want to make that
decision, they want the people to do it. So they are
really shirking their job.

···

R205: I guess being that I've worked for home care and
I've worked for the government for 25 years, I think
that you have to have more people that work on the
front line to know what's going on. People that have
no idea of what's going on, some of the decisions are
made with not as much knowledge. Plus lots of the
board have their own agenda.

5.3.2 Accountability

One of the effects of the restructuring process is

to transform the lines of accountability. Under the

current system, the health board members are not just

accountable to the Minister of Health, but to the

community members[10].

There is evidence that the boards perceive

themselves to be more directly accountable to the local

population. In the HEAL*Net* survey, for instance, the

majority (79%) of the Saskatchewan board members felt

that they were more accountable to the residents of

their districts[11].

In the interview, the district health boards were

asked if the regionalization had changed how accountable

decision-makers are to the local population. The

majority of the board members responded that there was a

definite increase in their accountability to the

community members [Table 5].

Table 5: The Accountability of the Board Members[a]

Question	Response and Percentage Score			
	More Accountable	Less Accountable	Remained the Same	Don't Know
Has regionalization made decision-makers more accountable to the local citizens, less accountable or has accountability remained the same	85	0	10	5

[a]Sample size N=20

There is a distinct link made in the responses between

accountability and the use of elections:

I: Has regionalization made the decision-makers more
   accountable, or less accountable to the local
   citizens? Or has accountability remained the same?
R203:I think it's more accountable.
I: Okay. How has it become more accountable?
R203:I think because they're watching pretty close with
   that, and if anything, it just seems like they're
   watching to make sure that ... which is good. If
   you're doing something you're not accountable to
   anybody, it could end up as a job not being done very
   well. It's the way I believe.
                      ...
I: Has regionalization made the decision-makers more
   accountable or less accountable to the local citizens?
   Or has accountability remained the same?
R212: For me, accountability rests partly with those who
   elected me, so part of the onus is on them to make me
   accountable, and to call me to account for certain
   things, so it isn't so much what I do completely as an
   elected individual. The public at large cannot
   abdicate their role in this. They have to make sure
   that they show up at meetings, that they let me know
   their concerns. That kind of thing. They have to
   remain in touch. As far as the actual individual, I
   suspect it's still almost up to the individual
   themselves how accountable you make yourself. Some of

us feel it a little more strongly than others. Some
get elected and they completely forget about that
aspect of it. Again, if the public, the other
component is not there to call you to task, there are
no repercussions for not being accountable for your
decisions. The appointed ones, ya. The appointed
members, that's strictly on your own volition, I mean,
hypothetically the way the system is now set up, with
elected individuals, does create an environment for
those individuals to be accountable, very accountable.
I mean the system is in place, it's what the
individuals do with it, I think, that I can see would
be a bit of a problem. The framework is in place.
Very accountable elected individuals. I don't think
there's anything else necessarily ... it's how those
individuals interpret it and what they do with it.
                    ...
I: Has regionalization made the decision-makers more
    accountable to the local population, less
    accountable, or has accountability remained the
    same?
R111: Yeah, I think so very much.
I: How has it become more accountable?
R111: Well, elections. That's the ultimate
    accountability.
                    ...
I: Has regionalization made the decision makers more
    accountable or less accountable to the local citizens?
R208: More accountable.
I: How has it become more accountable?
R208:It is mandatory to have two public meetings and that
    is an improvement over the bill. And the public holds
    the boards more accountable as well by again
    expressing concerns and questions and actions taken
    more now than in the past. And people can express
    their concerns through the elections.
                    ...
R109: Okay. So you ... well I imagine we're accountable
    for what we do. And that is related to the local
    elections, we can be voted out so we have to be more
    accountable.
                    ...
I: Has regionalization made the decision-makers more
    accountable or less accountable to the local
    citizens? Or has it remained the same?
R201: More accountable. I feel very accountable to the
    people who voted me in. I feel that the board

though, is not always acting accountable. There's a separation between the board and the people. We need to be more visible or more open. Some members don't want to be more visible or open. We sometimes forget who we are and why we're here. For the tough questions, you have to be accountable and justify your decisions.

5.4 Community Participation

The 1993 reform movement in Saskatchewan health care provided certain procedural changes that have the possibility of facilitating community participation in the health care sector. For instance, each health board holds at least two public meetings per year, so that the local people can come to the board with their concerns. Other structural possibilities for participation include involvement in needs assessments, writing campaigns, advisory groups, fundraising, presentations to the board, or via a complaints personnel. Yet, the quality and quantity of community participation depends on the willingness of community members to become involved, and the presence of structural constraints that may impede involvement.

Citizen participation in health care remains a very complex issue. People often do not become involved unless they or a loved one have a pressing health related concern. But more, citizen apathy and cynicism

over their real role are important considerations when
dealing with participation. If these important obstacles
can be overcome, then participation may be more readily
fulfilled. As it is, the results show that participation
in the Saskatchewan health care system has the
structural capacity to include people in the decision-
making. However, these structural changes require the
will to become involved on the part of local people, as
well as the willingness of the board members and the
Saskatchewan government to include them in important
decision-making. The health care system is therefore in
a state of transition; the reform has led to the
conditions for the democratization of health care
decision-making; however, certain contradictions must
first be overcome.

First of all, the formation of the boundaries is
presented. Next, the complexities involved in
implementing avenues for participation are explored.
These complexities involve the development of avenues
for participation, how community members are actually
becoming involved, and finally, the obstacles to
participation. It can be concluded that there are
structural possibilities for community participation.
There are some issues, however, which need to be

addressed, such as citizen apathy.

5.4.1 The Nature of Participation

A third change inherent within the program of regionalization is the implementation of both formal and informal mechanisms for community participation. Section 37 of the *Health Districts Act* requires each board to hold at least two public meetings in a year. Within these two meetings, the boards shall present: "(a) an operation and expenditure plan for the next fiscal year; and (b) a report on the health status of the residents of the health district and the effectiveness of the district health board's programs"[42].

There are other suggestions made by Saskatchewan Health for the facilitation of participation in board decision-making, even though these are not legally binding. For instance, joint needs assessments, open board meetings, public meetings, community representation on advisory groups, informational surveys of key community leaders, are a few of the possible mechanisms mentioned by the government of Saskatchewan for soliciting participation[43]. In another document put out by Saskatchewan Health in 1996 entitled *Involving the Public in Decision-Making: A Practical Guide to Communications*, practical communication avenues and

procedural tools are again presented to enhance the

participation not only the local people, but also

services providers, and district employees, within the

decision-making process. Added to the suggestions are

face-to-face discussions, open-line shows, toll free

phone numbers, Internet address, newsletters and

brochures, public opinion surveys, posters, direct mail,

speaking tours, and consultation with specific groups[44].

Accordingly, localization could enhance the ability

of all the members of the community to become more

involved. Indeed, it is essential that:

> The commitment and involvement of residents of
> your district, of community groups, municipal
> representatives, health care workers and their
> representatives, and other health providers or
> stakeholders should be actively sought.
> Appropriate representation of ethnic and cultural
> groups is important. The planning group should be
> aware of community power or social structures,
> and find ways to seek out the contribution of
> those who may be excluded from that structure or
> who are traditionally overlooked when considering
> community service[45].

The goal here, therefore, is one of inclusion. The

Wellness program itself is premised on increasing: "the

meaningful involvement and participation of health

consumers, communities, and health professionals in the

planning, delivery, and governing of health services

while respecting the diversity of our population"[46].

First of all, the institutional boards (e.g. hospital, home care and ambulatory boards) were amalgamated into the regional health boards. The respondents were therefore first asked if they had served on a hospital, home care, or ambulatory board, in order to ascertain any similarities or differences between the two systems[47].

The respondents who stated that they had previous involvement in the institution boards were queried about the extent of community participation in these boards. For the respondents, there was community involvement only to the extent that the boards were composed of local people who were appointed by the municipalities: "We were all local. Our particular one was appointed by the town, by the local RM. That's where we got our mandate. And I think it was pretty much true for all boards across the province". The selection of board members was a local matter according to another respondent, which included the local community members:

I: Who were they elected by?
R212: By the RMs. The RMs owned the facility so they were elected. Once a year they had an annual meeting where the community was involved. This is where they were updated as to what happened, what was going on, and there was major decisions that needed to be made outside of the board itself. And now, actually, we have two meetings.

It does appear that public meetings took place in the previous board system, but that it was the sole avenue for involving community members beyond the involvement on local boards.

Community members, however, were instrumental in the formation of the health districts. Indeed, explicit within the reform program is the involvement of community coalitions in the planning and development of their district boundaries[48]. Two of the respondents were involved in the early creation of the district boundaries. According to these board members, the local people had control over the process of developing the health regions. One of the respondents clearly articulates that the local people, not the central government, were responsible for forming the health regions:

R109: We set up our own boundary. We were in there before the government even started.

The setting up of the district was a matter of choice. For instance, one respondent stated that each municipality had to make the decision about which district to join:

R109: We as an area, a municipality, looked at actually four districts to see which district we could go with. We could go with Riverdale, we could go with Morrin, we could go with [one region], or we could go with [another region].

In the case of one of the districts, several
meetings took place among the facility and community
representatives to decide which district to join. One of
the respondents stated that the people involved in the
decision-making itself were those who were involved in
some area of health care and the local municipalities:

R109: They were somewhere in that they all had a
    connection to something to do with health care in
    their community... And quite a few of them were also
    members of council of rural municipalities or towns,
    not all of them, but there was quite a few.

Moreover, the meetings took place well before the
restructuring process of 1993. In fact, in one comment
by a respondent from the district, communications
between the hospital boards, and communities was an
important first step in creating a workable health
district:

R109: Okay, let's go to the beginning of [the district].
    And there we, I was not involved personally in this
    but we would, at our local hospital board meetings,
    we could get brought up to date by our
    representatives about what was happening. This is
    back in about 1986 when this started. They started
    looking at this set up from Morrin, and Jenkins,
    Riel and Karris. The four places. And what they
    first started out doing was looking at group
    purchasing. They would go together and get a better
    chance to purchase, maybe get a little cheaper
    purchasing. And from there it worked around until
    they sort of got discussing and talking and when the
    study came around in 1987, there was 15 districts
    they had figured out. And it went along primary,
    secondary, and tertiary health care and we pretty
    well studied that through. And the Morrin Hospital

District - they did a study of their own at what
things should look like. And they did a study on
just those four, the four I mentioned, and then
further on, they did the study on services taking
into account Lakeview, Balfour, Karris, and I guess
that would be it. And it was very much along the
lines of what the district is now. It was the study
of 1987 and their study came out I believe in June
of 1991 and from there then, everything sort of
started orienting the board setting up the
boundaries. Harrisberg decided that they would like
to become part and parcel of it, in fact, they were
in earlier than some of those like Jenkins and
Garvins and Riel; they came in sooner than them into
[the district]. And Devon, they were overlooking
four health districts, and they decided to come with
us. So that's why it's stuck on that far side there.
Right away we already had our thoughts of what we
wanted the district to look at.

The beginning of the reform process therefore, did have

success in including community members in the decision-

making. Rather than determining the boundaries by fiat,

the provincial government left the decision-making over

how the districts would be formed up to the local

people. The oddly shaped districts are a testament to

the choices communities made over which district to

join.

The restructuring process incurred changes to the

importance of involving community members in the

decision-making process. That is, one of the possible

outcomes of the 1993 reform is the inclusion of local

people within the decision-making beyond the electoral

process. The district board members were thus asked

about the nature of local participation within their districts. Community participation is indeed an important goal for the health districts.

Ensuring that the local people do feel a part of the decision-making process is an important consideration for the board members. When they were asked how community members participated in board decision-making, public meetings, needs assessments, advisory boards, telephone calls, presentations at board meetings, and the use of a complaints personnel were mentioned.

Under Section 37 of the *Health Districts Act*, the district health boards are required to hold at least two public meetings in a year. The *Act*, however, does not stipulate community participation within its mandates, only that they be used by the boards to report their operational and expenditure plan for the next fiscal year as well as to report on the health status of the residents of the health district and the effectiveness of the district health board's programs. Yet, there is some evidence that the public meetings are used as a means by which local people are able to express their concerns. Whether their concerns are in effect taken into consideration, however, remains a point for debate.

When the board members were asked how community

members participate within the board's decision-making,

the public meeting was one avenue mentioned:

I: How do the community members participate in board
   decision-making?
R203: Well, I guess just by the information we get...
   The public meetings are where we hear what their
   concerns are.
                    . . .
R211: We're having two public meetings a year. There are
   30 minutes set aside for presentations. This makes
   sure that people can present their views.

The structure of the public meetings is an

important consideration for effective listening. The

rural district health board, for instance, has

structured their public meetings to ensure greater ease

in participation:

I: How are these public meetings conducted?
R101: Well basically there is opening remarks. Both the
   CEO and the board chairman give opening remarks and
   then we divide into small groups around a table and
   what we do is we put at least one, depending on how
   many board members are there, perhaps even two board
   members to a table mixed in with the general public.
   And then the staff that are in attendance that we
   would call management staff, they tend to float
   table to table and answer specific questions that
   may come up or sort of chat with people. And that
   is the format that we have had for quite some time
   and it seems to work well. I think on an informal
   basis people are more likely to verbalize their
   feelings as opposed if they have to stand up in a
   hall where there is 50 people lined up in chairs.
   For some people this is a little intimidating. So
   this seems to have worked well for us. We actually
   have a format, which I guess you can say are leading
   questions that we use to get the discussion going.
   But my experience is that sometimes the discussion
   veers off in a different direction if there is a

particular topic that the people at your table want
to discuss. But we try and cover those questions,
which help us to see how the people are feeling
about the services offered. For instance, are they
pleased with them, are there ways they feel we can
improve or do they feel there is a very large gap in
the system. That is the type of information that we
are looking for which will assist both management
and the board in the planning process for future
services.

The meetings in one district are often advertised

through a publication mailed to the households in the

district as well as through other means:

I: How are they advertised?
R101: Posters. I have to admit that I don't listen to
    our radio station, but I am assuming that probably
    they are advertised on our local radio station...
    Also by our local papers and notices. I am sure word
    of mouth has a lot to do with it too.

Both health districts utilized the needs assessment

in order to gain information on the health status and

health needs of their local residents. However, for both

districts it is also a means by which the local

constituents are able to voice their concerns:

R208: We had just done a needs assessment and that was
    an avenue for the citizens to express their
    opinions. And those were all taken into account.
                        ...
R211: The public makes a contribution through the needs
    assessment.
                        ...
R205: We just had a needs assessment. When it is gone
    over it will show where the citizens feel changes
    should be made.
                        ...
R206: There again, with needs assessments, we do go to
    the citizens for their opinions and that.

Another means for including community members is a
facility advisory group. These groups inform the board
members about the need for services, particularly in
long term care. For instance, one board member district
stated that:

R108: We have our local advisory groups that pretty much
follow the old hospital boundaries. They're very
much attached to a facility you know, most of them
have a long-term care facility and that is kind of a
connecting point for them. They have the opportunity
to participate through that. And most every
community has an advisory group or a foundation
that... more people in the community are interested
in what is happening with health care particularly
with the long-term care facilities and they will
meet regularly. Within that advisory committee will
probably be the director of care from that facility
so that they have a liaison with management. They
work with management because management may either
want some things and they either can request them on
a form to the board members or through this. A lot
of these advisory groups or committees still have
trust funds set up and they may make the request to
have some of that money spent for a particular thing
that they want to see done in their community.

Community members also participate through local
fundraising efforts for specific programs or
infrastructure needs in their communities. This allows
them to have some control over the care of their local
facilities. Often, fundraising is used to pick up
funding shortfalls. One board member thus states:

R101: I guess community members are involved in
fundraising. Most of the communities, maybe all the
communities, have foundations that generate
donations or fund-raise in some way and they are a

very important part of our system because at the
present moment, the provincial government is not
coming up with any amount of money for capital
expenditures for capital projects. If you have
something such as a renovation to a building or
something there may not be funding available for
that service. So your foundation would be an avenue
that maybe would assist in that area... An example
would be in Riel that we needed a new roof on our
hospital and there was not provincial funding
forthcoming for that so money had to come - a great
deal of it - came through local channels.

Therefore, as another board member **(R205)** states: "There

is a group of men in the district who raise money. When

we don't have the money, then it has to come from the

residents themselves".

In one health district, community members are

encouraged to voice their concerns and opinions through

a quality care coordinator who reports back to the CEO

and the board members:

R101: We have a quality care co-ordinator in our district
as I assume that most of the districts do (I am not
familiar with the others). That is the channel
through which we encourage people that if they have
concerns about the service of any kind, to channel
their concerns through that quality care concern co-
ordinator... Some people don't bother passing on the
bouquets; they just pass on the concerns.
                              ...
R105: We don't get comments directly to the board; they
are supposed to come through a complaint person. They
go to her and if she can't deal with them with
policies that are already in place then she may come
to the board with the problem.
I: This complaint person... is she part of the
administration or is she part of the board?
R105: She is part of the administration; she is not a
board member. She is what you would call a director.
I: Would she report back to you at the board meeting?

R105: She reports more to the CEO and then he would
determine whether she should come to the meeting. She
has been at every meeting.

Another avenue for community participation is
through the local elections. As one board member **(R212)**
commented: "They [community members] elect the
representatives to serve at the board for them".

Central to the participatory agenda is the matter
not only of how participation is manifested, but also
the questions of who participates and whose values
influence the decision-making. This means that the
people who are affected by the decision-making have the
opportunity to have their voices heard. If interest
groups, experts and bureaucrats to the exclusion of the
community members, are influencing the boards then
community participation becomes more of an ideal than
reality.

The inclusion of people in the decision-making
process means providing a public space for people to
communicate with those they have elected to represent
their interests. In the PECOS study, for instance,
community members in southwest Saskatchewan were
surveyed on their normative perceptions of inclusion[49].
The results show that a majority (84%) of community
members agreed that patients should have a greater say

in how their health needs are met. Moreover, 82% of the
community members agreed that nurses and other health
care providers should have greater input into the
planning and providing of health care services in the
region[50].

The interview data reveals that the district board
members agree that their boards are inclusive of all the
members of the community. Indeed, 75% stated that their
district board was inclusive, while 20% stated that it
was not inclusive [Table 6].

Table 6. The Principle of Inclusion[a]

Question	Response and Percentage Score		
	Yes	No	Don't Know
Is your board's decision-making inclusive of all the members of the community?	75	20	5

[a] Sample size N=20

For some, the ideal of including everyone in the
decision-making process was being realized through the
existing mechanisms (i.e. public meetings, needs
assessments, etc):

R101: Well I guess our public meetings are open to
everyone.
I: Do you have an example?
R101: Yes. I guess we would provide some services as
needed in Hutterite colonies so that I would hope
that when those services are provided that the people
providing our services hope our resources are
providing information to them as far as our services.

I am sure that they would be. Most services are in the
area of nursing either in the public health nurses or
home care nurses or whatever. That is one sort of
population that we do have in our district that may be
a little different than the mainstream.

...

R102: Well, for aboriginals, we don't really have any
here. The Hutterites, the Hutterite colonies, I think
they're taken into consideration.

I: How?

R102: It's like they're can be, they've been invited to
meetings to participate. I don't know what has
happened from day one, I don't know if they have met
with certain communities or with the Hutterites,
especially, I know that they have met with other
groups, ... I don't know, if it's not types of service
groups or disability groups, or ... I guess to find
out where the need is.

...

I: Do you feel that the board decision-making is
inclusive of all the members of the community
including aboriginal, youth, women, Hutterites, the
elderly, etc.?

R202: I think so, ya.

I: Okay. What steps have been taken to ensure that this
has happened?

R202: Our needs assessment that we just had recently. We
met with I think it was 10 different focus groups that
included all of them - the Hutterites, teen mothers, I
am not sure exactly who was all on the list but 10
different focus groups made up of everybody basically.

...

I: Do you feel that board decision-making is inclusive of
all the members of the community, and here I mean
including women, aboriginals...

R103: Oh I think so.

I: What steps have been taken to ensure that this occurs?

R103: Being open to welcome phone calls and listening at
public meetings, just general listening to staff when
you need to, and so on.

...

R206: Well when we do the needs assessment we tried to
cover a good cross-section of different needs and
different sectors, especially with the phone survey,
we wanted to make sure that there was an even, you
know, proportionate according to sex and age and all
that kind of stuff. And the poor people along with

the more affluent. And of course, since this
district has a lot of seniors, it seems that a lot
of things revolve around seniors, I know that we
have to be very aware of young mothers and
teenagers.

Other board members, however, argue that the decision-

making process is not inclusive of the whole community.

One member, for instance, argued that the board decisions

reflect their own interests rather than the geographical

makeup of the community:

R110: No, I think we try. I don't think that it's that we
don't try to, but I think again we all bring different
perspectives and different vantage points and I don't
know one of us who is in poverty. I don't know one of
us who's a single parent mother. I don't know one of
us who's ever been starving. I don't know any of us
who can't put clothes on our backs, so I don't think
we're ... again, it's that representation thing. I
don't think there's no gender, there's no racial
stuff, like none of us, mind you there's very few
racial issues in our district. But, I think they've
done the best they could as far as putting the board
together, but no I don't think it's inclusive. I think
we need more kids on there too. I don't think it needs
to be a real age thing, I really see that age thing. I
mean it's pretty hard to address the needs of youth
when we're all old. You know? I think there should be
kids actually, at least advisory groups, but nothing.
But then again, and we should be paying them to come
there too.

Another board member **(R201)** stated that there is a lack

of reflection on these groups during the board meetings:

"If you go through the minutes you would notice that

there are hardly any motions on these groups... There are

hardly any decisions affecting these groups".

Moreover, when asked which has more influence on their decision-making, community or expert knowledge, half of the respondents argued that they valued expertise over community-based knowledge [Table 7]. What is interesting to note however, is that community knowledge is valued, at least to some extent, but the other half of the board members. Indeed, a significant minority (35%) argue that there needs to be a balance between community knowledge and expertise.

The split in opinion does describe the nature of the boards themselves. The board members themselves are local people (be they farmers, nurses, educators, etc…) who have volunteered their time to make the decisions. Needing the information compiled by experts is important to understanding the complex nature of health care. But there is evidence that board members do have some value for local custom and expertise. This could be accounted for by the political nature of the boards, since they are accountable to the local people for their decisions. What is reflected in the responses, however, is the desire for balance in their decision-making - by recognizing that the information provided by techno-bureaucrats and management, while important for decision-making, cannot form the sole basis for it.

Table 7. The Influence of Expert and Community Knowledge[a]

Question	Response and Percentage Score		
	Expert	Community	Both Expert and Community
Which has more relevance to your board's decision-making: Community knowledge or Expert knowledge?	50	15	35

[a]Sample size N=20

The following are typical responses that reflect the

dependence on technical expertise:

R210: I would say expert knowledge. The only community input in that sense comes from the actual board members who are elected from a community. There has been very little other supplemental external advice or whatever you want to call it.

. . .

I: OK. Which has more relevance to board decision-making, expert or community knowledge?

R107: I've got to say expert knowledge.

I: How does it have more influence?

R107: We get our expert knowledge from our management staff and we base our decisions on that.

. . .

I: Which has more relevance to your board decision-making - expert or community knowledge?

R201: We hire more people to do things now, more experts. We tend to rely on experts. This burns me cause they don't come up with things that we don't already know. Very frustrating.

. . .

I: Which has more relevance to board decision-making, expert or community knowledge?

R107: I've got to say expert knowledge.

I: How does it have more influence?

R107: We get our expert knowledge from our management staff and we base our decisions on that.

There were some concessions made, however, to the

need for community-based knowledge to at least

supplement the use of technical information.

For a sizable minority (35%), therefore,

community knowledge is also needed in order to

fully understand health care issues within the

region:

R101: I would say that both would influence us. I mean
that I don't think that either one would have the
exclusion of the other. And again, it would depend on
what the item was on the table for discussion too.

. . .

R102: I think that it would have to be both. I think that
each has a perspective to give to a situation.

. . .

R206: We need both to make a proper decision. You need
the community for the community input and you need the
experts to know what's happening with the staffing and
such.

. . .

R111: I think that the community influences our board a
lot. But then our experts, we bring them in to rein us
in when we are out of sync with reality. An example I
think about is, when we brought up optomology,
bringing it to our community. But when we talked to
the so-called experts, they reined us in a little bit
on this because of their knowledge about this and
their connections with other districts that have tried
this. They got the truer picture so we were a little
unrealistic with our community input. We were faced
with reality. We had to back off.

There is some evidence that the public sphere is

emerging within the district health board structure. For

instance, the board members argue that there are some

avenues that community members can take to ensure that

they are included within the decision-making process. Moreover, while past experiments with regionalization reveal the domination by experts, there is some evidence that the contributions of all the community members are valued. This may be partly due to the fact that the majority of the board members are elected and wish to serve the interests of their constituents.

5.4.2 The Extent of Community Participation

However, while there are certain avenues made available for community participation, how they are being realized is important, since reality may not necessarily mesh with expectations. How community members are participating is therefore presented. This begins a description of the problems inherent within participatory programs.

While there are opportunities for community members to participate, the actual participation of citizens, according to the majority of the board members, is minimal. Yet, there is evidence, that community participation may be more of an ideal than a reality. For instance, according to one board member, their community participation is minimal:

R209: Minimal, minimal. I mean, when you go back to your other question, we are certainly aware of what the needs are in the community, and that seems to be loud and clear. But as far as you know, drawing

from that every month, it is not happening.

The extent of community participation is therefore an important consideration, since even if a forum is open for people to voice their opinions, if there is no interest or ability to do so, then the possibility of a common consensus on health care issues is moot. For instance, voter turnout for the local elections in both regions was poor. One board member **(R205)**, for instance, stated that there was a real lack of interest in voting: "I mean, with 25% voting in the election, people just aren't interested".

Furthermore, finding someone to run for a board seat is somewhat difficult. One board member **(R207)** states: "There isn't a great turnout for candidates which hurts accountability". Another board member reiterates this:

R101: There wasn't the interest in the election to the health board that some people assumed there would be. An example would be in the town of Jenkins. There were no names put forward to begin with... I guess everybody just sat back and said that somebody else would so why should I and so nobody did.

This lack of interest is associated with the perception that being a board member could result in being stigmatized by the local community members, particularly if tough economic choices are needed:

R210: There is a lot of trouble getting people to run

for the board because of the stigma, the negative
decisions that are inevitably made, the decisions
that impact, the bad news decisions that impact on a
small community like this. Nobody wants to be a part
of that. No one - very few people are willing to
run.

Moreover, there is evidence that people do attend

the public meetings. However, both groups of board

members argue that attendance is minimal, and could be

improved. For instance, one board member stated that:

R209: We will have a public meeting and there are [a
good number of] people living in Morrin and you get
maybe 150 attending. Unless there is a burning issue
then you will get a minimum.

       ...

R205: Even with the meetings, only about 300 show up and
they're either mad or have an agenda.

       ...

R202: At our public meetings we get turnouts of about
150-200 people and there is the same 6 that stand up
and grumble. So you get a lot out of those ones but
6 out of a town of [a good number of people] isn't
very many.

The situation is the same for the more rural health

district. The board members argue that effort is made to

include the local people in the decision-making through

the public meetings. However, despite their efforts, the

public meetings are poorly attended:

R101: Well the last ones that we have had have been held
in fairly small communities. For instance, the
spring one was held in Karris and I don't know what
the head count was but it would have been around 30
people of the general public. There could have been
people who were not a board member, who were not
staff, so for a community like Karris that is
probably pretty good.

       ...

R111: I'd like to see a larger public meeting, better attendance. They haven't been too bad but it would be nice to have 50 instead of 25 in these small towns. We have had up to 30 which is good but the more the better.

...

R109: Oh, I would think that they're there, but when we have twice yearly meetings, we get a very poor turnout, so maybe that should be rated very low then. Because not many people come to find out what is going on. They're satisfied I guess.

...

R103: Well, I think maybe there is even more community involvement in that we now have at least two public meetings per year... we strive to have public meetings but they are poorly attended, but we do hold them.

I: Why do you think that they are poorly attended?

R103: Maybe people don't care. Obviously we have had them at different times of the day and night and at different locations, you know, east side, west side of the district, and so on. But we do have better attendance than Saskatoon. But still, it's poor.

...

R107: We have public meetings and they don't show up for them and you know, we invite villages and RMs, councilors and leaders and such and they don't come. We really respect their opinions and maybe would do what they would ask if they presented their problems to us. But they don't. Sometimes I think that something drastic has to happen before they would ever do that. Like maybe a closure or something like that. Then we would get a response from them.

Participation, then, is connected to the existence of an important issue for the communities. This is clearly reflected in the following response from **Respondent 202:** "You get the idea that the community just doesn't care until there is a public meeting and then they will come bash you. You don't hear any input

until they want to come holler at you". The public
meetings, therefore, are a chance for the local people
to come and voice their concerns, although the
participation tends to be in reaction to the decisions
that have already been made.

The reactive nature of community participation is
notable. According to the majority of the board members,
when the community members do participate, it is mainly
in reaction to decisions already made. While open
communications is an ideal for the board members, the
practice is to reveal the information to the public and
then have them present their concerns after the fact.
The following statement from **Respondent 209** reflects the
responses of the majority of the board members: "Yah,
they are more reactive than proactive. Most of the time
when they come in they are coming in on decisions that
have been made or are being thought about". Other
responses certainly reflect this sentiment: "Decisions
are already made – but you can give them insight into
what's being done later." Another board member **(R206)**
states: "No community input. All they've [board members]
ever done is to provide financial information to the
community. In most cases, they've just ignored the
concerns of the community. Communications is

deplorable." Another board member states that citizen

reaction is usually evident when a decision has been

made which is unpopular with the local people:

R208: Mostly they react to decisions that have already
been made and that is quite evident in attendance.
When there's a decision made that causes some
controversy in the community there are very large
numbers that come out. When the health plan is
announced and presented to the public as a plan for
future action and asks for their input, there are
few people that come out.

The ability of citizens to become more actively

involved, however, depends in part on structural

openness. Allowing the people a place to make their

contributions is essential in ensuring public

participation. As one board member states, this may be

realized through allowing people to make presentations

to the board in order to impart information and

concerns:

R210: Nine tenths of the time I would say reactive. The
odd exchange with the board itself is proactive. We
have provisions for people to make presentations to
the board simply for information purposes. The
problem is, no one ever advertises so nobody ever
came. We've been trying to get the word out and we
have had the odd presentation which was simply for
the exchange of information and it's been very
positive. Sometimes it's for the initiation of some
sort of health care initiative, so I would say that
qualifies as proactive. But no. Most exchange is
either one on one, or public meetings, or focus
groups or needs assessments.

Partly, the onus is on the community members

themselves to become more active in the decision-making:

R202: I think that at our public meetings that they
should come with suggestions and their ideas on what
they want from health care, instead of criticism
over what we have done, at anytime. That is one
avenue for them to come. They can also write letters
and give us ideas instead of leaving decisions up to
us and then criticizing the decisions.

The participatory nature of the health board decision-

making, therefore, requires that people are willing to

become involved in the decision-making, or to become

more educated. For one board member, the nature of

participation is affected by how the community members

understand the nature of health. The over-reliance of

people on institutional care, for instance, may be more

difficult to change:

R110: Reactive. It's kind of hard to know algebra unless
you've read algebra and you've understood algebra. So
I think it's pretty hard for a lot of people to have,
like their understanding of health care is based on
their needs. You know, I mean people don't realize
that, you know, prevention services for children and
youth might prevent hospitalisation or whatever down
the road. People just care about getting in a
hospital. So there, you know, it's definitely
reactive. That's why I think there's so much focus on
the hospital because it's tangible, they can see it,
and that's what they want. And it's now. People like
the quick stuff; they like to know that it's now. They
don't want to wait.

Moreover, another board member stated that the

community members are not necessarily willing to educate

themselves about how the health care system works, a

situation which can lead to antagonism and

misunderstanding:

R210: Part of what I'm going to say the onus is on the
public because people being people, I know, will
judge without getting the facts. They also make
assumptions about what the board's role and function
is and it's often the wrong assumption. Those who do
understand what the board's role is as opposed to
management's role, don't generally have a problem
with board decision-making. But the majority of your
input in the past and present is the community
public meetings, and the relationship [between board
members and community members] has been very
antagonistic, very negative. You can only educate
people if they want to be educated or if they want
to listen. Some do, some don't... Some people don't
want to listen to no one no how and so explaining is
not going to make a difference. So they remain
antagonistic. We will always get that element I
think, at any public meeting or interface we have
with the public.

Ensuring avenues for participation, therefore, is

the first step for creating a program of community

involvement. Partly, the onus is on the community

members themselves to educate themselves and utilize

these avenues. If there is a lack of community

responsibility, according to one board member, the

board's decision-making exists in a vacuum:

R212: I think that if they are electing a person to
represent them at the board table, I think it is a
responsibility to inform them that they also have a
responsibility to report feedback. And it is through
a public meeting where communications take place; it
could also take place in letter form. But I think
people seem to sit back and when they are unhappy
they do a lot of talking about it. But they are not
busy when things are going good or when they don't
have concerns. So, I think that the people have to

> sit up and take responsibility to a greater level. I guess, that one of the examples is that when we had a crisis situation going on over a year ago, they phoned me up and said that when we elected you that these types of decisions would be made. And I said excuse me, that is not what I expected, that you elect me and then abandon me and expect me to carry your full load. Like, if you have a problem with something, it is your responsibility to communicate to me. So if you have anything that would suggest that I bring this motion back to the board table in facts, you might as well do that because you have asked me to do that. I hold a lot of onus on people to communicate their issues to their elected representatives. Like these are some of the current concerns that we have and I would like my representative to bring them to the board table. That is their responsibility. And if it is not happening, then the elected person is not doing their job and no other people are doing their job.

Respondent **212** further states that: "[community members] have to be more willing as participants to work with the boards. To understand and become more educated about everything related to health". An inability to become involved and educated could hamper the progress of community participation.

5.4.3 Obstacles to Community Participation

The ability to get people to participate, therefore, is marred by certain inconsistencies. The success of a participatory democracy is certainly dependent upon the willingness of the local people to take control. Yet, according to the health board members, this is not necessarily the case. One board

member **(R202)** states it simply: "I don't think a lot of them think about health care". The main obstacles to community participation noted by the board members are citizen apathy and the lack of citizen knowledge about health care services. Indeed, when asked to rate the extent to which each factor was an obstacle to community participation, citizen apathy and the lack of knowledge were rated as the most problematic. A lack of time was less of an issue and the distance needed to reach the board office or public meetings was overwhelmingly viewed as irrelevant.

One important obstacle to community participation is the lack of citizen knowledge about the role of the health board and its internal mechanisms. Here, 70% of the respondents rated a lack of citizen knowledge as an obstacle to community participation [Table 8].

Table 8. The Extent to Which a Lack of Citizen Knowledge is an Obstacle to Community Participation[b]

Question	Percentage Score				
	1	2	3	4	5
To what extent is a lack of citizen knowledge an obstacle to community participation?	0	15	15	20	50

[a] The table is a scale of degrees. 1 represents "not an obstacle at all" and 5 is "an important obstacle".
[b] Sample size n=20

Most of the responses were that a lack of knowledge is an obstacle to community participation. This is evident in the following statement from **Respondent 205**: "The public is just not knowledgeable about how things are run. They just expect us to do things, but they aren't aware of the role that finances play in the governing options of the district". In one board member's estimation, the lack of citizen knowledge translates into a lack of controls on spending. People's expectations about what the health care system can provide and the reality of cost controls, for instance, can be irreconcilable:

R212: They don't want to become educated. Out patients is a very good example. It is costing a lot of dollars to have patients come in with a sliver in their finger or whatever. When they could go to a physician's office. They are costing us a lot of dollars.

Partly, this hindrance is due to the complex nature of health care itself:

R208: That is a major factor.
I: In what way?
R208: Health care is a complex issue and a lot of people still go by hearsay instead of finding out facts and becoming knowledgeable and it is a difficult field to become knowledgeable in, in the first place.

Another board member who states that the lack of citizen knowledge is due to the lack of time people have to fully comprehend the complexities of health care

reiterates this:

R110: I don't think people have time to learn about
things or have an understanding of the effects of
NAFTA or the effects of a multi-lateral agreement on
health care, and truly, that's what this is all
about. And I think that when people do have the
time, I think it's so terrifying that they just
don't go there.

One respondent, for instance, states that the

health boards do make an effort to educate the public,

but that people do not use the information until it is

needed:

R101: Well I would like to think that we keep our
citizens well informed but my experience tells me
that people traditionally, and I think it is human
nature, that people do not pay attention to
information on certain things or programs when it is
put out at that time. They don't have any interest
in it, or they don't need it. So when the time comes
that they do have to access that service, they maybe
don't have the information then on how to ask the
questions.

There is a sense, then, that the information being sent

to the community members is not being effectively

utilized. One board member, for instance, expresses a

certain amount of frustration over the lack of interest

among community members in reading the materials sent

out to them:

R212: Because I think that you can put all kinds of
information out there, all the information you want
- but if it isn't affecting them at that moment,
they don't read it and later on they will say, well,
you didn't give us the information. And we can go
around in circles and spend an enormous amount of
time trying to inform them and the end result will

still be the same.

Another barrier to community participation is citizen apathy [Table 9][a].

Table 9. The Extent to Which Apathy is an Obstacle to Community Participation[b]

Question	Percentage Score				
	1	2	3	4	5
To what extent is apathy an obstacle to community participation?	10	0	25	45	20

[a] The table is a scale of degrees. 1 represents "not an obstacle at all" and 5 is "an important obstacle".
[b] Sample size n=20

As one board member **(R202)** states: "Oh, that would be an important obstacle then to community participation. Because if they don't care, you don't get any community participation". For one board member, being apathetic about health care is related to the reactionary nature of community participation and the culture of paternalism pervading society:

R110: I think that we have been so brainwashed into thinking that other people will take care of us, that we are very apathetic. A lot of people just sit back. And they are only reacting when things go wrong. And I still think that's their choice. I think society has put us into that, I think that's really really sad.

The pervasiveness of citizen apathy in western culture is not merely a condition of health care. According to one board member **(R102)**: "I think apathy

happens all over and I don't think there's anything we can do about it, but it is a hindrance, a big obstacle I would think". Another board member states that apathy is not just an obstacle for the health care system, but rather, is symptomatic of a general lack of interest in local boards:

R208: As compared to what? Like you have apathy on school boards and city council deals with apathy. I don't think that it is any different for health care than it is for any other issue that a community faces.

Nevertheless, people are less apathetic about health care because it has more of a direct impact on individuals. The same respondent **(R208)** goes on to state that: "In fact, there might be a little less apathy in health because it does affect more people directly than some other issues that are in the community". For another board member, the lack of interest in health care is cause for concern, since health care is an important consideration for every person:

R210: They're apathetic in the sense that they don't show up, they don't really participate. It's very hard to even get people to buckle down and write a letter of protest... but I would also counter that to say that I think that health care is very much a part of everyone's life, and I think to a certain degree, even if it's subconscious, most people are aware of just how important it is. So it just baffles me some days why, because they've all got a vested interest, why they don't come out, even to one meeting a year. Or write one letter of protest if there's something going on that you don't like,

just write one letter to the right person.

The lack of time is less of a hindrance to community participation than apathy and the lack of citizen knowledge. Indeed, only 30% of the respondents rated time factors as a significant obstacle to community participation. Just under half of the respondents (45%) rated it very low as an obstacle [Table 10][a].

Table 10. The Extent to Which a Lack of Time is an Obstacle to Community Participation[b]

Question	Percentage Score					
	1	2	3	4	5	Don't Know
To what extent is a lack of time an obstacle to community participation?	15	30	20	30	0	5

a The table is a scale of degrees. 1 represents "not an obstacle at all" and 5 is "an important obstacle".
b Sample size n=20

For some board members, time is not an issue when making decisions. For instance, **Respondent 105** states: "This is not a big obstacle because we usually have time to do the planning and everything".

For other health board members, the board may not have enough time to meet with the public. **Respondent 206**, for instance, states: "It seems like we deal so much with things that happen within our management and

all that kind of stuff that we don't take enough time to do the community things. It's just that health care is changing so fast that it's hard to keep on top of everything". Another board member **(R212)** states that meeting with the public is not necessarily cost effective: "It is very costly in time and time is money. So there isn't enough dollars to continually... like you can involve people in it like the two times a year, so I guess what I have to say is that time is money and it always takes time. You have to have the administration time to prepare all the stuff".

Other board members interpreted the issue of time constraints more in terms of the lack of time the public has to effectively participate. In Saskatchewan, for instance, people may not feel that coming to the board meetings is an effective use of time:

R210: I think it is with all of us... in the sense I would gather that people have to pick and choose what to do with what little free time they've got. For as many years as there's been health boards, the public meetings have not been a place where you... friendly atmosphere where you could go have some input, ask questions, receive information. Therefore over the years, the public impression of these meetings is that they're a waste of time and there's much better things to do like go to a hockey game or whatever. No, it's not very high on people's list of priorities to choose to spend their free time going to them, no.

5.4.4 Normative Participation

There are other solutions mentioned by the board

members. When they were asked how community members

should be involved, some responses reflected the need of

the district health board to become more open:

R201: The board should have more public meetings and the
board meetings should be more open to the public. We
need to network with interest groups. Be more
visible- whether it's through volunteering or just
through caring about the concerns. The perception
is... when people see us doing something it would
have such a great impact. We have the opportunity to
get people to come out to the public meetings and
voice their concerns. We need to do more than just
be there - we need to encourage people to present. A
large part of the reform is new to the community
members, not just the boards (such a small
component). We should ask what the community members
want and tell them about the reform.
                    ...
I: In your opinion how should community members be
involved?
R202: I think that at our public meetings that they
should come with suggestions and their ideas on what
they want from health care. Instead of criticism over
what we have done. At anytime. That is one avenue
for them to come, they can write letters and give us
ideas instead of leaving decisions up to us and then
criticising the decisions.

I: In your opinion, how should the community members be
involved?
R110: I think that we're representatives of the people
and therefore if they can't come and talk openly to
us, then again, there's no point of being there. We're
ambassadors of our health district and we bring in
information from our communities. And if we're not
open and honest people and willing to listen and take
the time - well then we shouldn't be on the board.

Other responses reflect the need for the community

members to simply become more active in the already
established avenues. There are some suggestions made,
however, to increase the number of public meetings, to
encourage people to become more active in fund-raising,
or just to utilize the services that are present:

I: In your opinion, how should community members be
involved in board decision-making?

R207: We should have advisory committees (not that they
should make the decisions, but to give us the pulse
of the community). Have more public contact, such as
smaller meetings where smaller groups can come and
have round tables. There should be more of an avenue
for the submissions by community groups. These
submissions should be proactive because there is no
participation. We did have a complaint line. We have
an avenue by which community members should send in
suggestions. If there are about 300 suggestions
about the same thing then that would influence the
board decision-making.

. . .

I: In your opinion, how should community members be
involved?

R205: There should be more open meetings - public
meetings. Two just doesn't give us enough of a
chance to see what is really going on. There should
be a lot more letters going out from the board
stating what we are doing, mostly to tell people to
come to meetings and voice their opinions. More
education is also needed to ensure that they know
the issues at stake. There should be open board
meetings, so many hours in the month so that people
can come and learn what we are doing and why, to
learn what the roles are for the board, management
and the department.

I: In your opinion, how should the community members be
involved?

R102: I think they can be involved by participating in
public meetings and letting us know what their needs
are. I think if they don't then we don't know, you
know, what is needed out there.

. . .

I: In your opinion, how should community members be involved?

R103: I think at public meetings. Certainly there is a chance to voice their opinions.

. . .

R105: We do have as part of the board have two public meetings a year and we try to hold them in two different areas of the district so that any interested people can come. Last one happened to be here in Garvin and we had a pretty good turn out. The other way would be to let them know that if they have any complaints or concerns about health care to contact this director. I don't know if you want the name or if that matters or not, but rather to come directly to board members if they have a complaint around Garvin to come directly to me, then that would make me prejudice towards my own area.

. . .

I: In your opinion, how should community members be involved in board decision-making?

R108: Well I think that we feel, and we've really promoted local advisory groups, so that if people have concerns, you know, bring them through them. These are not just the care issues but things that they would like to see done in their community in the area of health services. They go through that group.

. . .

I: In your opinion, how should community members be involved?

R109: Well, we do it. We hold twice yearly meetings and invite them all to come. Though, I guess if they have a gripe, there's the co-ordinator again. What else would you have ... that should ... and elections. That's the main one I guess. Number 1 priority is elections. If you don't like the board members, elect somebody else. Or don't like what the board is doing, I guess.

. . .

I: In your opinion how should community members be involved?

R101: Definitely their input. Either certainly in suggestions, change or improvement. I mean people at the grassroots sometimes see things that other people don't. Or maybe people have had some experiences where something happened that maybe or could have been differently or done better so if they pass that input on it could lead to change

which would be an improvement. You certainly want
that. I guess community members are involved in
fund-raising, most of the communities maybe all of
the communities - I would have to stop and write
them down but they have foundations that generate
donations or fund raise in some way and they are a
very important part of our system because at the
present time the provincial government is really not
coming up with any amount of money for capital
expenditure for capital projects. If you have
something such as a renovation to a building or
something there may not be funding available for
that service. So your foundation would be an avenue
that maybe would assist in that area.

I: Okay.

R101: They are very important and if this hold back or
whatever it is for the fact that we are not getting
capital funding if that continues those foundations
and fund-raisers will become even more important.
Because in our district and I am sure in many
others, we have quite a number of buildings which
our managers call infrastructure which is probably a
good word, an aging infrastructure and those
buildings need maintenance and repair. And sometimes
the maintenance is a very large thing. An example
would be in Riverdale, that we needed a new roof on
our hospital and there was not provincial funding
forthcoming for that so that money had to come a
great portion of it came through local channels. The
foundation was involved in that.... So that is a
very important and appreciative role in our district
and other districts as well.

5.4.5 Influences

To more fully understand the principle of inclusion,

the board members were then asked the degree to which

community members, service providers, the provincial

government and interest groups influenced them in their

decision-making.

The most influential segment was Saskatchewan Health

[Table 11][a]. Indeed, 75% of the respondents argued that

Saskatchewan Health is an important influence on their

decision-making.

**Table 11. The Extent to Which Saskatchewan Health
Influences Board Decision-Making[b]**

Question   Percentage Score

	1	2	3	4	5
To what extent does Saskatchewan Health influence your board's decision-making?	0	0	25	45	30

[a] The table is presented on a scale of degree. 1 is "not
an influence at all" and 5 is "an important influence"
[b] Sample size n=20

One of the direct means of communication between the

board members and the provincial government is through a

government representative. He or she attends the meetings

giving the board information from the provincial

government and reporting back to the government the

activities of the board. The presence of the

representative was viewed by some of the board members as

constituting interference by the provincial government:

R103: We have a government representative sitting at the
table all the time. Any decisions that are made,
they quickly run back and tell the Minister of
Health and if he or she isn't happy, it doesn't
happen.

...

R212: We're recently going through something where the
board set management the task of coming to a balanced
budget, it required hard-nosed decisions, there could
possibly be some very serious cuts to services. The
government representative came along and very strongly
influenced the meeting.

Some of the board members commented that the provincial government set out the guidelines for the districts:

R207: Four. We have the Act, policies and procedures which you adhere to. You have to stay within the parameters of the documents. We have a service agreement that we adhere to. The service agreement says what the Minister will provide - money - and what we'll provide - services.

...

R110: Oh, they're the leaders, I mean the provincial government is a representation of the population as a whole, so if they're not guiding the district health boards, I'd be extremely concerned. I mean, as a resident of this province, if they... not only Saskatchewan, but the Federal government, you know, if universalism to all those principles aren't adhered to, I'd be extremely concerned.

The community members within both regions were also influential in determining the direction of the decision-making, although one third of the respondents argued that community members either only sometimes influenced them or never influenced them [Table 12][a].

Table 12. The Extent to Which Community Members Influence Board Decision-Making[b]

Question	Percentage Score				
	1	2	3	4	5
To what extent do community members an influence the board's decision-making?	5	10	15	50	20

[a] The table is presented on a scale of degree. 1 is "not an influence at all" and 5 is "an important influence"
[b] Sample size n=20

The following are typical responses:

I: What about citizen opinions and expectations?

R202: Oh pretty high, that would be a 4.

I: How do they influence your decision-making?

R202: That is where the accountability comes in... as a board our mandate is to listen to the public and bring their concerns to the table. If they have any concerns that is exactly why we are here.

...

I: What about citizen opinions and expectations?

R102: I think that it would be about a 4 too because we're looking after the needs of the citizens of our district.

...

I: What about the citizen and community expectations?

R212: That's definitely... yes, and it can even be a small citizen-type group, but I would rate that up there with a 4 also. I've seen it even before I was on the board. Public grassroots committee, there was a great deal of influence over my particular board decision and they are very sensitive, I think all the districts are to some extent. But the government is too. Which is why we were told not to cut our services last month. So in this area, yeah, if people yell about something, even in small groups, they can make substantial waves. They are listened to.

The service providers are somewhat influential segment [Table 13][a]. Here, only 50% of the respondents stated that the service providers had any real influence. Twenty-five percent argued that service providers never influenced their decision-making.

Table 13. The Extent to Which Service Providers Influence Board Decision-Making[b]

Question	Percentage Score				
	1	2	3	4	5
To what extent do service providers influence the board's decision-making?	10	15	25	30	20

[a] The table is presented on a scale of degree. 1 is "not an influence at all" and 5 is "an important influence"

[b] Sample size n=20

Some board members argued that the service providers are

a very important consideration since they were the ones

with the first hand experience of the service provision

and are essential to the operation of the district health

care system:

I: What about the service providers?
R203: At least a 4
I: How do they influence your decision-making?
R203: Because we have a lot of respect for them. They're
      heavily involved with servicing, know all about it.

...

I: And what about the interests of service providers?
R107: 4
I: And again...
R107: Well, because we've got to keep our staff happy. We
      have to keep them content. Our biggest amount of our
      budget goes out to staff salaries.

...

I: What about the interests of service providers?
R206: Yeah. I regard it quite highly. You know, they're
      the people who are working for the community first
      hand, and I think... I'd say a 4. I regard their
      opinion quite highly.

I: What about the interests of service providers?
R209: That is high, about a 4, because they are the front
      line and certainly they are the ones that... that if
      their interests are not being met then the job just
      isn't getting done to satisfaction at all.

...

I: What about the interests of service providers?
R110: Oh always influencing, about a 4
I: How so?
R110: Oh, because they're the people who have been in the
      trenches and if we don't listen to them, they're the
      ones that have the big picture, they're the ones that
      are the experts in their own field of work. If we
      don't listen to them, it's like being in a family and
      not listening to your mom or dad. I mean, I think that
      it would be a great detriment if we didn't pull on the

expertise of the people who we have employed. In fact, in my opinion, those should be the people who are integral, even more so than the community. I think that it should be balanced. Then you could listen to everybody.

For other board members, they know that the service providers have needs that should be addressed, however, because of the low budgeting, the demands of the service providers cannot be fully met:

I: What about the interests of the service providers?
R202: No, I don't think that... well in my opinion that would be low.
I: What would you rate it?
R202: A 2 I guess. Like in some of the decision, you can't... say for instance you had to cut a service or something so those service providers would be gone... you almost have to look at them on paper instead of - you can't get personally attached to somebody. You have to work within your own budget.
　　　　　　　...
R205: Okay. We're low staffed. The morale is terrible. So, and we know all this stuff, that they need more staff and they need more beds, they need all that stuff and it comes back down I guess to ... any time in health care, sick time and all those things, are really large, and it comes back down to finances again. We can't afford to replace all the time. We can't afford to give them more staff, so ... and this is ... they want all that, so ... I'm not sure how I'd even rate that one, how they influence us. We know what they want and we know what they need, but it's just about impossible to give them what they want, so for them to influence us — they try to, but there's no feasible way we can help them out.

Others are yet more emphatic about a lack of influence by service providers stating that service providers influence them, **as Respondent 207** argues: "very little", or, as **Respondent 201** states, that: "they do not

influence us at all".

The role of physicians in determining policy is also important. There is some indication that physicians are influential in the determination of public policy. The HEAL*Net* study for instance, found that while 59% of Saskatchewan board members did not agree that physicians were more influential than other district residents, a sizable minority did agree (41%)[51].

The interviews did not explicitly include physicians as a group when determining what factors were influential in the board's decision-making. Yet, a number of the respondents mentioned the role of physicians. From the responses it can be surmised that the physicians in the districts do have some influence.

The influence of physicians was made through the Chief of Staff for their district who is invited to attend each board meeting to represent the interests of the physicians. There are also medical advisory committees, which keep the board members informed of the needs of physicians. The interview data does indicate that the physicians do have a good deal of influence over the decision-making:

R110: Well, you know, that's an interesting question
     because without the physicians, that's a real
     interesting dynamic. How do they influence it? Oh,
     they influence it, all right. And how they influence

it. They have access. And they have power. And so
anyone who says they don't have an influence, I would
really question, because they do have lots of power
and they're there.

What is clear from the responses from both the

boards, is that physicians are undergoing a period of

adjustment to the reform changes and that this plays a

role in their influence:

R109: I suppose a physician in the days of acute care
hospitals and that, they were pretty well the person
that made the decisions of who and whom would be in a
hospital bed. Now through the new system, the doctors
are given criteria that they have to meet to be able
to access acute care and sometimes they like to revert
back to their old system. Especially keeping all the
beds full.
...
R108: We certainly have had a reasonable working
relationship with the physicians. Some don't always
agree with us but work with the board and really
want to change the health care system. But, but I
think that the board has to be realistic and
recognize where they are coming from. This has been
a time of change for them as well as for everyone
else, so, I think, you make allowances for
disagreements that you have and if we disagree that
doesn't mean that we can't work together again and
do some very positive things. We have a medical
committee, a medical advisory committee that their
president comes quite regularly to our board
meetings and we have a medical officer, chief of
staff that comes to all our board meetings. He has
really good input. It's really important to work
with the doctors because they have a vast influence
upon people and I think that we get some negative
things from doctors about health reform, the doctors
have a mike and a willing and ready audience to
listen to them. And some of their arguments are
probably quite valid.

Explicit within the period of adjustment has been a

measure of negativity on the part of the physicians. For

instance, one theme that emerges in the interview data

is the perceived threat to their professional autonomy

and power. This is evidenced in the following responses:

R212: Doctors, especially hold sort of the whole gamut of
things. It is also turf protecting and conflict
issues. They don't allow things to progress. So
basically you almost can't make some decisions because
they're sort of at the gate and stopping what we do.

I: How are they stopping you?

R212: Well decisions especially, if you want to go to
salary doctors, or nurse practitioners and all of
those types of things. They don't want to let go of
their power. There is no decentralisation, like they
don't want to transfer a function. Doctors' don't want
to transfer a function to nurses and nurses don't want
to transfer a function to special care aid.
Department heads don't want to transfer a function.
They don't want to go down and say okay everybody is
responsible for things within a district. Unions are
influencing continually, that they are over worked and
underpaid and whatever else. So a lot of that is
around decision-making. Especially the physicians
because they do hold a lot of power and that would
have to change... Physicians don't want to transfer a
function down. They still want to be seen as the
ultimate or the "god" of health. They have to do a
whole lot more preventative medicine practicing.
They have to be willing to work with us to create
and make the changes necessary for empowerment.

> ...

R211: The doctors sort of feel that they know it all.
They don't like being told what to do. They are
partially right - but they have to be part of the
system, not run it.

> ...

R105: We have one physician in our district but he seems
to go against our decision with home care; he doesn't
agree with home care and that. Therefore, there is a
difficulty with someone who doesn't want to give up
how he feels about his powers. We have somewhat
difficulty that way.

I: So what is happening is that he doesn't feel that home
care should be approved?

R105: Yes, I think so. And the whole theme of the new health care reform is send things back to the community. They have more involvement with community nurses and home care.

...

R201: We had a physician review done here and it wasn't good, so it ticked the physicians off. The physicians and boards have never had any real kind of relationship. Physicians are in their own little world. But they're so separated. They are closely related to us, but separate.

There is an element of compromise, however, between the

boards and the physicians. The following board member

argues that the physicians are a necessary part of the

health care system and their voices should be listened

to. Again, however, there is a power dynamic present

within the response:

R111: I would say middle of the road again. We don't let [physicians] overpower us but at the same time we don't want to exclude their knowledge or leave them out because they have some good points. It's a 50-50 thing. We can usually pick up on a physician who is blowing his own horn, so to speak, and when he's not. And we're not intimidated by them either.

One important point here is the future relationship

between the boards and the salaried physician:

R202: It is getting better, I guess. We just had a little trouble with the Chief of staff and the physicians were against the board. That matter has changed and I think that they are coming around.

I: How has it changed?

R202: Well for a while they would have nothing to do with the board. Now they are willing to work with us a little bit more and we are getting some doctors that are going to be directly employed by the district, so we will be their boss instead of just giving them a hospital to work out of.

Another issue mentioned is the difficulty in "enticing"

physicians to relocate to rural areas:

R109: In rural Saskatchewan, we have a, when a doctor
leaves or dies or whatever, that position doesn't get
filled anymore. We cannot entice doctors into rural
Saskatchewan. Like a one doctor practice. You know
what that is — 24 hrs. a day, 7 days a week.

Finally, the least influential segment of the

population is interest groups. Fifty percent of the board

members argued that they were never influenced by the

needs and expectation of interest groups, including

unions, SAHO (Saskatchewan Association of Health

Organizations), pharmaceutical companies, etc. [Table

14][a].

**Table 14. The Extent to Which Interest Groups Influence
Board Decision-Making[b]**

Question	Percentage Score				
	1	2	3	4	5
To what extent do interest groups influence the board's decision-making?	20	30	35	10	5

[a] The table is presented on a scale of degree. 1 is "not
an influence at all" and 5 is "an important influence"
[b] Sample size n=20

There are indeed indications that interest groups'

influence is minimal:

R108: Certainly interest groups have a role to play, and
we as a board listen to them. But that doesn't mean
that we do everything that everyone wants us to do.
I guess that's the mandate of the board is to meet
and sift through that and pick out what is valid for
our community and what is going to lead to good
health not only today but in the future, in the

long-term future of the health of the community.
They're certainly listened to and sometimes have
good ideas.

...

I: And how about interest groups? How do their
objectives influence board decision-making?

R201: Not to a great extent. We tend to have an open ear
to SAHO and consider their viewpoint, for instance,
but the influence isn't that great.

...

I: What about interest groups?

R101: The influence?

I: Yes.

R101: I can't say in our district that we have been ...
I can't think of an incident that a decision was
greatly swayed by a special interest group.

...

I: What about interest groups?

R107: I can't think of an example of that at all.

...

R206: Yeah. Well we don't really have those people per
say coming to the meetings. Of course we hear what's
happening with the unions and that there again that
comes through our CEO.

...

R211: We do listen to the complaints of interest groups,
but they don't have that much influence.

...

R202: I don't think that we do. We take them into
consideration, but when it comes right down to it
we don't try to pick and choose and try to please
one group over another.

A third change inherent within the program of

regionalization is the implementation of both formal and

informal mechanisms for community participation. The

inclusion of locally elected people is one means of

ensuring local participation, for one, it allows local

people to set the agenda for their own particular area.

For another, the political nature of the boards may ensure that the voices of the community members are taken seriously by the board members and have some impact on the direction of policy.

There is evidence that the voices of the community members are taken seriously by the board members and that provisions are made to ensure community participation. For instance, the boards do hold 2 annual meetings, and particularly for one board, the meeting is structured through the use of round table discussions to allow people more comfort in speaking. Also, moving the public meetings from town to town was used to ensure that different communities in the region would have access to the public meetings.

Other mechanisms employed by the boards to ensure community participation include the needs assessment (which is not legally mandated), the use of advisory committees, which give an organized community voice which include all the segments of the population (here, the elderly, people from Hutterite colonies, etc are invited to make presentations to the board). Both boards have complaints personnel set in place who fields the complaints from the community members.

Community members have a great deal of influence

over the decision-making process. For instance, while half of the board members argued that expert opinion is central to their decision-making, the other half argued that community members were at least equally important.

However, there are issues that the board members brought up which need to be addressed - for instance, the willingness of community members to become more actively involved. Citizen apathy, time constraints, etc, are important factors that need to be addressed.

Notes

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[1] Here, it should be noted that the variable of citizen apathy only serves to describe the board members' interpretation of why people are not participating. Community members may have other reasons for not attending board meetings.

[2] H. Dickinson (1993). The Struggle for State Health Insurance: Reconsidering the Role of Saskatchewan Farmers. *Studies in Political Economy*. Volume 41

[3] *Ibid.*

[4] Saskatchewan Health (1984). Report on the Ad Hoc Committee on the Role of Regional Boards of Health

[5] J.T. Macleod (1973). *Consumer Participation, Regulation of the Professions, Decentralization of Health Services*. Department of Political Economy: University of Toronto. p. 116.

[6] *Ibid.* p. 118.

[7] J. Steed (1995). Health Crisis isn't Unique to Ontario. *The Toronto Star*. Sept 24: A1.

[8] Saskatchewan Health (1992). *A Saskatchewan Vision for Health: A Framework for Change.*

[9] Health Canada (1995). *Health Reform in Saskatchewan.* p. 4.

[10] World Health Organization (1986). *Ottawa Charter for Health Promotion*. First International Conference on Health Promotion Ottawa, Canada, 17-21 November 1986.

[11] *Ibid*, p. 1.

[12] H. Dickinson (1994). The Changing Health-Care System: Controlling Costs and Promoting Health. In B. Bolaria and H. Dickinson (eds). *Health, Illness, and Health Care in Canada (2nd edition)*. Toronto: Harcourt Brace and Company, p. 121.

[13] *Ibid.*

[14] *Ibid.*

[15] J. Epp. (1986). *Achieving Health for All: A Framework for Health Promotion*. Ottawa: Health and Welfare Canada.

[16] Health Canada (1996). *Health System Reform in Canada.*

[17] *Ibid.*

[18] Health Canada (1995).

[19] Province of Saskatchewan. *Chapter A-18.1 An Act respecting the Establishment of Ambulance Districts and Boards, the Licensing of Ambulance Operators and Emergency Personnel and the Provision of Ambulance Services in Saskatchewan.*

[20] Province of Saskatchewan. Chapter H-4.01. *An Act respecting the Provision of Home Care Services.*

[21] Saskatchewan Health (1995). *A Framework of Accountability: The Minister of Health and District Health Boards.*

[22] *Ibid.* p. 2.

[23] Saskatchewan Health (1993a). *Introduction of Needs-Based Allocation of Resources to Saskatchewan District Health Boards for 1994-1995.*

[24] S. Lewis (1997). *Regionalization and Devolution: Transforming Health, Reshaping Politics?* Paper based on a Presentation to the Robarts Centre Symposium, Toronto, April 1-2 (1996).

[25] The information is found on the Saskatchewan Health website:http://www.health.gov.sk.ca/ph_district_mgmt_ser vices.html
Accessed July 2001

[26] Health Canada (1995).

[27] J. Lomas, J. Woods, and G. Veenstra (1997). Devolving Authority for Health Care in Canada's Provinces: An Introduction to the Issues. *Canadian Medical Association Journal.* 156(3): 371-377.

[28] *Ibid.* See also Lewis (1997).

[29] J. Carver (1990). *Boards that Make a Difference: A New Design for Leadership in Nonprofit and Public Organizations,* San Francisco: Jossey-Bass Publishers. p. xvii.

[30] *Ibid.*

[31] *Ibid.*

[32] *Ibid.*

[33] *Ibid.*

[34] H. Dickinson & R. Torgerson (1998/1999) Health Reform, Empowerment and Community Sustainability. *Health and Canadian Society.* 5(2): 203-224.

[32] Under the municipal ward system, board candidates run in geographically set areas and thus act as the representative for their local area.

[36] The information can be found on the Saskatchewan Health website: http://www.health.gov.sk.ca/ph_district _governance.html
Accessed July, 2001

[37] *Ibid.*

[38] In some districts, such as Regina and Saskatoon, the provincial government may appoint up to six board members.

[39] The information here can be found on the Saskatchewan Health website: http://www.health.gov.sk.ca/ph_district_ governance.html Accessed July 2001

[40] Saskatchewan Health (1995). *A Framework of Accountability: The Minister of Health and District Health Boards.*

[41] D. Kouri *et al* (1997).

[42] Health District Act (1993) Section 37.

[43] Saskatchewan Health (1993b). *Planning Guide for Saskatchewan Health Districts, Part 1: Strategic Planning.*

[44] Saskatchewan Health (1996). *Involving the Public in Decision-Making: A Practical Guide to Communications*: p. 33.

[45] Saskatchewan Health (1993b). p. 2.

[46] Saskatchewan Health (1992). *A Saskatchewan Vision for Health: A Framework for Change.*

[47] None of the board members reported serving on the public health region councils, therefore the points of comparison are made with the hospital, ambulatory and home boards. Of the twenty respondents, six reported past experience with the institutional boards.

[48] Saskatchewan Health (1993). *A Guide to Core Services for Saskatchewan Health Districts, Discussion Draft.* p. 3.

[49] H. Dickinson & R. Torgerson (1998/1999).

[50] *Ibid.*

[51] D. Kouri *et al.* (1997).

6. DISCUSSION AND CONCLUSIONS

Chapter Six provides a description of how health

care regionalization is being implemented in

Saskatchewan and how it relates to the democratization

of public policy. It is generally concluded that the

structure of regionalization in Saskatchewan is

conducive to a program of democratization, but that

there are issues that require further exploration.

Section One provides a general synthesis between

the research findings and democratization. Section Two

provides a discussion of devolution and the ensuring

issues that develop, such as the possibility of

political manipulation by the provincial government.

Section Three likewise sets up a discussion of local

elections and how they serve to enhance the

accountability of the decision-makers and ensure that

the people that make the decisions are representative of

their constituents. Section Four looks at the avenues

for public participation within regionalization. There

are several factors here again which need to be

addressed, for instance, citizen apathy. Finally,

Section Five develops further questions that require

further development. For instance, there are some issues

that need to be dealt with in greater detail, for instance, how a consensus can be realistically achieved in the public meetings, and how public deliberation translates into the viability of the rural community.

6.1 Regionalization and Democratization

There are structures set in place through Saskatchewan's health care regionalization that are conducive to participatory democracy. First of all, more responsibility for health care policy and service provision was devolved to the local level, thus developing the conditions for self-government and community-based decision-making. Secondly, the local health board structure was politicized through local elections. Here, local people are, at least partly, able to determine the composition of the board through the mechanism of local elections. Finally, while much of the mechanisms for public participation are informal, localized decision-making sets up a structure by which the local people have input into the decision-making process.

Local government, therefore, at least by the example of health care regionalization, has much to offer by way of increasing community empowerment, and while this is supposition at this stage, enhancing the viability of the community structure. This last point

needs further input since the connections between
regionalization and sustainability are mainly
inferential at this stage. Giving people more control
over health care policy gives people more of a voice.
How this is translated into the formation of a consensus
needs further articulation.

The structure of regionalization provides people
with a public forum within their own community, as
opposed to having policy determined solely by the
provincial government. This was the case with the
institutional boards; the provincial government "micro-
managed" the institutions. The provincial government
developed the policy regarding service provision, and
resource allocation.

Added to this is albeit sparse evidence regarding
the first experiments with regionalization boards in
Saskatchewan. Indeed, regional boards formed in the
1940s in Saskatchewan were reported to have had local
control as one of their determining principles[1]. By the
1980s, however, local control was eroded; the regional
boards became merely advisors to the provincial
government. That is, they served to provide information
about local culture and health needs[2].

Moreover, past experiments with regionalization in
other provinces and countries, for instance, the

regional experiment in Quebec provides evidence that
there is a difference between institutionalizing local
control and ensuring that it is realistically
implemented. In the Quebec case, one of the obstacles to
democratization was the domination of board decision-
making by experts (including health care professionals).
The formation of the public sphere, therefore, requires
that the local people not only be given the mandate for
self-government, but also become part of the decision-
making process. Consensus can only be achieved when all
the parties are able to provide meaningful input.

Indeed, history thus shows that while the structure
of regionalization has distinct possibilities for
community empowerment and local control, the reality may
be somewhat different. The evidence from this study does
show that the possibilities are there for the formation
of a public sphere that includes community members. For
instance, the regional health boards are composed of
local people. The *Health Districts Act* does provide for
the determination of policy by local people. According
to the *Act*, regional board members are not simply
advisors to the provincial government, but rather, they
are active participants in the formation of health
policy.

Thus, structurally, the regional boards do serve as the institutional site for the democratization of health care services at the community level. Structurally, there has been a transfer of control to the local level, an institutionalization of local elections and a value placed on public participation.

6.2 Devolution

The amalgamation of the institutional boards created some concern that by reducing the number of boards, people would be further removed from the centres of decision-making. That is, regionalization eliminated opportunities for membership on local boards. However, the results show that the institutional boards did not have much power to determine policy. Decisions were primarily top-down. The provincial government directed policy and the allocation of resources; the board members were responsible for carrying it out. There was little decision-making power on the part of the institutional board members, beyond, as one board member put it, "ordering trays".

Indeed, the institutional boards did not have any real powers to make decisions beyond the administration of their particular facility. Even then, the provincial government predetermined the allocation of resources. The provincial government "micro-managed" the

institutions, giving the boards a line-by-line budget to follow. Moreover, policy directives flowed from the provincial government to the institutional boards. The issues of local control over health care decision-making and community empowerment before the reform, therefore, need to be placed in this particular context.

One of the mandates of the 1993 health care reform movement was to devolve more responsibility to the regional health boards. Thus, the responsibilities of the new regional health boards under the *Health Districts Act* were expanded beyond the role of administrators to the development of policy and resource allocation. Under the regional system, the district board members are responsible for policy and service provision in such areas as mental health, public health and community health. The CEO (Chief Executive Officer), the boards' only employee is responsible for the day-to-day administration of the health care services, such as the hiring or firing of staff. Thus, there has been a transfer of responsibility downward.

The question here, however, is whether or not devolution is realistic. The structure after the reform was predicated on the devolution of powers to the newly formed regional health boards, giving the regional health boards more powers over policy development,

service provision and resource allocation. There is some

evidence that local control is not yet fully realized,

or at least the belief in local control is not

consistent among different social groups or at different

points in time. For instance, the HEALNet survey found

that the majority of the Saskatchewan regional health

board members argued there was an increase of local

control after the 1993 reform. Community members, on the

other hand, were less optimistic about the linkages

between local control and regionalization. In fact, only

a small majority of the community members surveyed were

optimistic that there would be a true devolution of

control. This is not entirely surprising due to the

instances of cynicism about the true intentions of the

provincial government with regards to rural issues. The

survey itself was done in 1995, only two years after

regionalization, and more importantly for the rural

communities, only a few years after 52 hospitals were

closed in Saskatchewan.

The interview data also reveals a split about local

control. Just under half of the board members stated

that local control had increased. An exploration of the

responses to the open-ended questions find that they

feel constrained by the government, and are subject to

the "meddling" of the provincial health department. This

is not to say that the boards should have full autonomy. The provincial government is responsible for the health of the Saskatchewan people and for ensuring the sustainability of the Medicare system. Even the representation of the province at the board table, while in some cases viewed as meddling by the provincial government, ensures that the boards adhere to the principles of Medicare and universal standards. Yet, the data reveals that the boundaries between the responsibilities of the boards and the provincial government becomes blurred when the decisions have been made by the district boards and the provincial government steps in and overrides them for political purposes.

One of the most poignant examples of this is the sudden influx of monies after the board members had either cut a service or reduced its staffing. The respondents felt that this served to discredit the decisions that the board members had made. This undermines their legitimacy. But more, Putnam made the point that the entity that controls the money really controls the decision-making[3]. The district boards therefore must balance the centralization of funding with local decisions - a balance that is not always smoothly achieved. The data reveals the very real

difficulty centralized funding has for making local decisions. One board member aptly stated that: "As far as funds are concerned, we're completely under the whim of Saskatchewan Health". There is no easy solution here, however. Local levying may set the conditions for true autonomy; however, it may also create differences in resources between districts. That is, the development of have and have-not districts is a real one if local taxation becomes a reality.

There is some evidence, however, that regionalization does enhance the responsiveness of the decision-makers. The board members from both the HEALNet survey and the interview felt that they were indeed responsive to the communities since they are located in the community and are thus more accessible than the provincial government to the people. The board members are people from the community and thus are understood to have insider knowledge of how the community operates.

6.3 Local Elections

The district boards are structurally inclusive. The composition of the boards interviewed for this study, while not fully explored here for the purposes of confidentiality, does reflect representation. Moreover, the evidence from the interview data reveals that board members are of the general opinion that regionalization

has made the decision-makers more representative of the local population.

Another structural consideration is that of accountability. Local elections have the structural capacity of allowing local people to have some determination over decision-making through a selection process. Thus the basic core of representative democracy; whereby the citizenry selects a representative to make the decisions is institutionalized in Saskatchewan.

However, there are some issues that need to be raised regarding the notion of representation. There is a possibility that the board would be comprised of people who reflect certain interests in the community, for instance, those who represent a facility, which is slated to be closed, or those who represent union interests. Other issues are related to the possibility that service providers are more likely to have a personal and professional agenda or that the provincial government, through its appointment of local people would use this as an opportunity to have their political interests protected. The data reveals that these are very real possibilities that the boards may face. The extent to which these interests force agendas, however, needs further exploration.

6.4 Community Participation

The structure of regionalization is conducive to local participation. The location of the boards within the community, for instance, may structurally allow for the development of a public forum. The public forum is further engendered by the *Act*, which stipulates that the district boards hold at least two public meetings. While the *Act* only requires that these meetings be used to relate information to the local people, there is a possibility that a more proactive type of participation could emerge, not just at the public meetings, but also through other mechanisms. What is needed is political will.

The data reveals that the inclusion of community members in the decision-making is a goal for the district boards, which is a necessary precondition for implementing participation[4]. For instance, while half revealed that their information comes solely from experts, a sizable minority (35%) argues that a balance between expertise and community knowledge needs to be achieved, creating the conditions at least for the principle of equal inclusion. Moreover, community members are reported to have a good deal of influence on the decision-making process. The only segment with more influence is Saskatchewan Health. Service providers are

less influential, and interest groups, such as SAHO, unions, pharmaceuticals, etc… are the least influential. One interesting theme that developed in the data is the political and social authority exercised by the physicians in the district. There is some inferential evidence that physicians are quite influential within the district due to their expertise and status. What emerges is that the willingness of physicians to accept regionalization is an important factor to its success.

There are other factors that may determine the direction of democratization. The ideal of community participation, for instance, is hampered by its realistic implementation. While public meetings were presented as a forum for community participation, the responses reflect that the public meetings were used to present information (e.g. financial reports) to the people. There is evidence that people do attend meetings, but that their participation is more related to strategic action, particularly when a pressing issue comes up (for instance, the closing of a long-term care facility). The actual participation by community members, when it does occur is more reactive than proactive. Thus, the quality of participation does not yet reflect the ideal of active discourse formation;

that is, participatory democracy is premised on the
reaching of a consensus by active citizenry[5].

The inability or unwillingness of people to take
political responsibility is thus an obstacle to the full
realization of participatory democracy. This could be
due to the reality of political participation in modern
society. People's willingness to participation cannot be
separated from the disengagement of people from
political decision-making. Indeed, the formation of a
political professional class (e.g. professional
politicians, lobby groups, interest groups), for
instance, has created a condition by which people may
not feel that their voices would be taken seriously. The
active citizen in this scenario cannot be achieved
unless their voices are legitimized.

One solution here would be a team approach to
decision-making where everyone who is affected by the
decision-making has equal input. This includes health
care providers and interest groups as well as community
members. The position taken here is that people cannot
be expected to know everything or even to have an
interest in everything. While a team may be developed to
look at issues of health care for their region in
general, a more single-issue approach may be preferable
so that people with a stake in the outcome of the

decision are able to volunteer for the team (i.e. on
anti-smoking campaigns, long term care, or child
poverty). The problems here of course are related to the
formation of individualistic interest groups that do not
necessarily mean an equal representation. What it can
mean is a more realistic, albeit more limited,
implementation of public participation. The process of
participation is important too, since what is needed is
a transformation of people's belief in their ability to
affect change.

6.5 Important Considerations

The crux of democratization is that decisions and
policy would be achieved through the process of reaching
of a general will formation. The means by which this can
be attained are at the center of debate. Reaching a
consensus means that everyone has the equal chance of
having his or her voices heard. How to achieve this
consensus in a complex society requires further
development. What regionalization does offer to this end
is a situation by which people may have a sense of
"community", or as Robichaud and Quiviger define it: "a
sense of belonging"[6]. The sense of community is,
however, assumed and therefore needs further
development. Putnam, for instance, offers insight into
the relationships between what he terms a "civicness"

and political action[7]. He argues that democratization can only transpire when communities are characterized by "civicness", or rather, an instance where the citizens "… regard the public domain as more than a battleground for pursuing personal interest"[8]. It means developing community cohesiveness based on political equality, solidarity, and cooperation.

Indeed, the most obvious problem with a study in the area of democratization is the value placed on the needs and expectations of the local population and if their contributions reflect instrumental or individual concerns or if there is a sense of community within the district with common goals and concerns. For instance, in a study like this one cannot totally separate how deeply into people's psyches state and market imperatives (through the steering forces of media and money) already affect people's concepts of health care. When one is conducting a study on how people are able to determine the direction of health care policy in their community, the underlying problem is that their opinions and levels of knowledge may be already pre-formed. Market forces (e.g. privatization and user fees) are important to the possible preconception people have about the health care system and the direction that it should take. Moreover, although the board members argued

that interest groups were the least influential to their
decision-making, the impacts of certain interests would
be important when evaluating the nature and quality of
decision-making.

The argument can also be made that returning to the
community lessens the impact of state intervention in
the area of health care and could be seen as an attempt
to once again individualize health care services and set
the conditions for more privatization and individual
(and community) responsibility.

Another important issue emanating from this study
is that the description of regionalization is made by
the health board members, the majority of which are
elected officials. Their responses do provide an insight
into the people who have volunteered their time to
become board members. They are at the "frontlines" of
the decision-making process. What is needed is what
democratization means to the ordinary person. This may
elucidate their perceptions on community cohesion as
well as the underlying issue of democratization.

The next stage, therefore, is to understand the
connections between community cohesiveness and
democratization. The idealized consensus needs the
active and inclusive participation of community members.
If community members are not participating, then the

question is why. Moreover, the community members may be a more valid source for understanding more clearly the connections between community empowerment and community sustainability. Indeed, an inferential connection was made here on how localizing decision-making is an indicator of sustainability. There were some comments that do begin this analysis. For instance, one respondent **(R105)** stated that: "Things are now local, decisions are made locally, so that may help bring us more together". The connections between institutional change (not just the existence of institutions) and the vitality of Saskatchewan communities, therefore, need to be further developed.

NOTES

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[1] J.T. Macleod (1973). *Consumer Participation, Regulation of the Professions, Decentralization of Health Services.* Department of Political Economy: University of Toronto

[2] *Ibid.*

[3] R. Putnam (1993). *Making Democracy Work: Civic Traditions in Modern Italy.* Princeton, N.J.: Princeton University Press.

[4] One issue here is how well health care providers are able to have their interests included in the decision-making. They are directed to go through the CEO who then reports the information to the board.

[5] S. Benhabib (1994). Deliberative Rationality and Models of Democratic Legitimacy. *Constellation.* 1(1): 26-52.

[6] J.B Robichaud and C. Quiviger (1991). *Active Communities: A Study of Local Community Health and Social Service Centres in Canada in 1988.* Ottawa: The Canadian Council on Social Development.

[7] R. Putnam (1993).

[8] *Ibid,* p. 88.

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APPENDICES
APPENDIX A: INTERVIEW SCHEDULE

IDENTIFICATION _____

Thank you for participating in this interview. If any of the questions make you uncomfortable or you would rather not answer them, just let me know, and we'll go on to the next question**

===

PART A: PAST BOARD MEMBERSHIP

First of all, I'd like to measure whether or not you perceive the district health boards to be different from the previous 400 or so hospital and single care boards.

==

A1. How long have you been a member of your district health board? _____

A2. Are you an elected or appointed board member?

_____

A3. Were you involved in the creation of the boundaries of your health district?

a) YES/NO _____ (IF NO, go to A6)
b) What was involved in the creation of the boundaries?

_____

_____

_____

A4. Tell me, before you became a member of the district health board, were you ever a member of a hospital, ambulatory or single care home board?

a) YES/NO _____ *(IF NO, go to PART B. IF YES, go to A5)*.
b) *(IF YES)*, was it as a member of a hospital board, ambulatory board or single care board *(i.e. home care)? (Indicate all that Apply)*
Hospital board (HOW LONG?) _____
Ambulatory board (HOW LONG?) _____
Single Care board (i.e. home care, community care)
(WHEN WERE YOU A MEMBER?) _____ _____
(HOW LONG WERE YOU A MEMBER?) _____ _____

A5. What was the role of your board in making the
decisions for your facility (region)?

_____

_____

_____

A6. What was the role of the provincial government in
the decision-making process?

_____

_____

_____

==
PART B: 1993 REFORM
==

B1. Do you feel that regionalization has led to an
increase or a decrease of local control over health care
service planning and delivery, or do you feel that local
control has remained the same?

Increase (go to a)
Decrease (go to b)
No change (go to c)
     Don't know/no response
a)   How has it increased?
b)   How has it decreased?
c) (no change) In what ways has it remained the same?

_____

_____

_____

.

B2. Do you feel that regionalization has made the decision-makers more responsive to the local population, less responsive to the local population? Or has there been no change?

More responsive (go to a)
Less responsive (go to b)
No change (go to c)
    Don't know/no response
a) How has it become more responsive?
b) How has it become less responsive?
c) In what ways has it remained the same?

_____

_____

_____

B3. In your opinion, has regionalization made the decision-makers more representative of the local population, less representative of the local population? Or has there been no change?

More representative (go to a)
Less representative (go to b)
No change (go to c)
Don't know/no response
a) How is it more representative?
b) How is it less representative?
c) In what ways has it remained the same?

_____

_____

_____

B4. Has regionalization made the decision-makers more accountable or less accountable to the local citizens? Or has accountability remained the same?

More accountable (go to a)
Less accountable (go to b)
Remained the same (go to c)
Don't know
a) How has it become more accountable?
b) How has it become less accountable?
c) How has it remained the same?

_____

_____

B5. For the next set of questions, I would like to know
what and/or who influences your board in reaching
decisions? On a scale from 1 to 5 where one is NOT AN
INFLUENCE AT ALL and 5 is "AN IMPORTANT INFLUENCE", to
what extent do the following influence board decision-
making?

i) Saskatchewan Health	1 2 3 4 5 6 (don't know)
ii) Interest Groups	1 2 3 4 5 6 (don't know)
iii) Citizen Opinions and Expectations	1 2 3 4 5 6 (don't know)
iv) The Interests of Service Providers	1 2 3 4 5 6 (don't know)
v) Anything Else?	1 2 3 4 5
(response) _____	

a) How does it influence decision-making?

_____

_____

_____

_____

_____

_____

OR

b) why does it not have any influence?

_____

_____

_____

_____

_____

B6. How do community members participate in board
decision-making?

_____

_____

_____

B7. In your opinion, how SHOULD community members participate in board decision-making?

_____

_____

_____

_____

B8. In your opinion, when community members do participate in board decision-making, is their participation within your decision-making mainly reactive or proactive?

  Proactive (go to a)
  Reactive (go to b)
  Don't know
a) How is it proactive?
b) How is it reactive?

_____

_____

_____

B9.Here, tell me to what extent each of these factors

are obstacles to community participation. The scale is

between 1 and 5 with 1 meaning "not an obstacle at all"

and 5 is "an important obstacle". Tell me to what extent

each of the following is an obstacle to community

participation.

i) a lack of time	1 2 3 4 5	6 (don't know)
ii) citizen apathy	1 2 3 4 5	6 (don't know)
iii) lack of citizen knowledge	1 2 3 4 5	6 (don't know)
iv) access to board office	1 2 3 4 5	6 (don't know)
v) Anything else?	1 2 3 4 5	
(Response) _____		

a) Probe - How is an obstacle?

_____

_____

_____

B10. Do you feel that board decision-making is inclusive of <u>all</u> the members of the community (including women, Aboriginals, Hutterites and the disempowered)?

Yes (go to a)
No (go to b)
    Don't know
a) If Yes - how is it inclusive?
b) If No - how is it not inclusive?

_____

_____

_____

B11. Which has more relevance to your board's decision-making: Community knowledge or Expert knowledge (i.e. technicians, health professionals, bureaucrats, academics)?

Community Opinion (go to a)
Expert Opinion (go to a)
Both have Equal Relevance
Don't know

a) Why do they have more relevance?

_____

_____

_____

B12. Have there been times when you have felt constrained by the provincial government?

Yes (go to a)
No (go to C12)
Don't know
 a) If Yes, How are you constrained?

_____

_____

_____

b) How are you not constrained?

_____

_____

_____

==

C. FOLLOW-UP

We have reached the end of the interview.
THANK YOU FOR PARTICIPATING IN THIS INTERVIEW!
==

Time End _____

Are there any final comments that you would like to make with
regards to this interview?

_____

_____

_____

_____

_____

_____

APPENDIX B. The Codification Scheme

B.1 Devolution

Past Structure: The information collected on the past
structure was exploratory; thus, the codes were
developed after several perusals of the interview data.
The questions related to the pre-1993 structure of
governance are categorized using the following codes:

i) **OLSTDUB** - structure of institutional board duties and responsibilities
ii) **OLSTDUS** - structure of Saskatchewan Health duties and responsibilities
iii) **OLSH** - The nature of the provincial government's control over decision-making in the past structure.
iv) **OLLP** - The nature of local control over decision-making in the past institutional structure

Current structure: The information gathered on the
changes to local control after regionalization are
codified as follows:

i) **COMIN** – how local control has increased
ii) **COMDEC** – how local control has decreased
iii) **COMSAME** – how local control has remained the same

The responses to the issue of whether the boards are
constrained by the provincial government are codified
using the following codes:

i) **CONSTRY** – how the boards are constrained by the provincial government
ii) **CONSTRN** – how the boards are not constrained by the provincial government

Other themes appeared within the data. The structure of
board management appeared throughout the interviews, the
issue of one-way funding and the use of the Carver model

for board administration[1]. These themes are codified as follows:

i) **CARVER** - responses related to the Carver model of board administration
ii) **ONEWAY** - responses related to the one-way valve of funding

Finally, regionalization has the possibility of ensuring a more responsive governance system since the local officials will be more aware of the opinions and expectations of their constituents. The information from the interviews that described the changes to the responsiveness of the decision-makers is codified using the following codes:

i) **RESPINC** – how regionalization has made the decision-makers more responsive to the local population
ii) **RESPDECH** - how regionalization has made the decision-makers less responsive to the local population
iii) **RESPSAMH** – how regionalization has not changed the responsiveness of the decision-makers

B.2 Local Elections

There were three possible inferential links made between local elections and democratization. First of all, the inference is made that the decision-makers will be more accountable to the local population. The codes used to classify any information gathered about this possibility are as follows:

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[1] The Carver Model of board administration is based on the premise that the role of boards is that of policy development and the planning of strategy. The day-to-day operations of the district is relegated to the district's CEO and his or her staff of managers. See for instance, J. Carver (1990). *Boards that Make a Difference: A New Design for Leadership in Nonprofit and Public Organizations*, San Francisco: Jossey-Bass Publishers.

i) **ACCINC** – how regionalization has made the decision-makers more accountable to the local population

ii) **ACCDEC** – how regionalization has made the decision-makers less accountable to the local population

iii) **ACCSAME** – how regionalization has not changed the accountability of the decision-makers

Another important possibility of localizing the decision-makers is that they will be more representative of the local people. The codes used to categorize the responses regarding representation are as follows:

i) **REPINC** – how regionalization has made the decision-makers more representative of the local population

ii) **REPDEC** – how regionalization has made the decision-makers less representative of the local population

iii) **REPSAME** – how regionalization has not changed the representativeness of the decision-makers

The responses are also analyzed through a simplistic statistical analysis in order to determine any patterns in the responses, for instance, if the majority of the respondents felt that regionalization made the decision-makers more or less representative of, and accountable to, the local people.

There were also other themes found within the data that are relevant to the construction of the regional boards. There were comments made regarding the inclusion of health care workers on the board, the appointment of board members, and the issue of being solely responsible to one's own ward. Thus, the following codes were used to classify these themes:

i) **HEALTHW** - the issue of health workers on the board

ii) **APPOINT** - the issue of appointed members being on health board
iii) **OWNAREA** - the issue of having prejudices towards one's own ward

B.3 Participation

The information that they provided was categorized as follows in order to provide an account of how the boundaries were set up:

i) **BOUNHOW** – how the boundaries were formed

One of the explicit intents of the 1993 reform was to facilitate community participation within the decision-making. How the two regional health boards provided for community participation were revealed in the interviews. The mechanisms that are identified are codified as follows:

i) **ASSESS** - the community participates through needs assessments
ii) **PUBLIC** - the community participates through public meetings
iii) **COMPLAIN** - the community participates through a complaints personnel
iv) **WRITING** - the community participates through writing campaigns
v) **PHONING** - the community participates by phoning the board office
vi) **PERSON** - the community participates through person to person contact
vii) **ELECT** - the community participates through local elections

The respondents are also asked how they think that the community should become involved in local board government. The normative responses are categorized using the following codes:

i) **ASSESSN** - the community should participate through needs assessments
ii) **PUBLICN** - the community should participate through public meetings
iii) **COMPLANN** - the community should participate through the complaints personnel
iv) **WRITINN** - the community should participate through writing campaigns
v) **PHONINN** - the community should participate by phoning the board office

vi) **PERSONN** - the community should participate through person to person contact

vii) **ELECTN** - the community should participate through local elections

Another set of themes that emerged from the data was the actual response of the community members to these mechanisms for participation. Indeed, the creation of mechanisms for participation is only the first step. The actual response of the community members to the avenues of participation is another important consideration. Through an exploratory reading of the interview material, the following codes regarding community response were identified:

i) **PMRESP** - the response by community members to public meetings.

ii) **PRRESP** - the response by community members to news releases, media and other public relations methods

iii) **ELRESP** - the response by community members to involvement with elections

iv) **WRRESP** - the response by community members to writing campaigns

v) **COMRESP** - the response by community members to complaints department

vi) **ASRESP** - the response by community members to the needs assessment

vii) **SYRESP** - the response by community members to surveys

viii) **PERRESP** - the response by community members to person to person meetings

The obstacles to participation were predetermined through the interview schedule and include time constraints, apathy, lack of community knowledge and distance from one's residence to the board office. The responses to this line of questioning are codified in the subsequent manner:

i) **OBTCH** – how time constraints is an obstacle to community participation

ii) **OBAPH** – how apathy is an obstacle to community participation

iii) **OBCKH** – how the lack of community knowledge is an obstacle to community participation

iv) **OBDIH** – how the distance from one's residence to the board office is an obstacle to community participation

The respondents were asked if they considered the community participation to be primarily reactive or proactive. The responses to this question were pre-determined before the data analysis and were codified as follows:

i) **PROACTH** - how community participation is proactive

ii) **REACTH** - how community participation is reactive

iii) **BOTHRPH** - how community participation is both reactive and proactive

The responses were later classified using the following codes:

i) **EXPERT** – how expert knowledge has the most relevance to the board's decision-making

ii) **COMMUN** – how community knowledge has the most relevance to the board's decision-making

iii) **BOTH** – how both expert and community knowledge have equally relevant to the board's decision-making

Another important consideration for community participation is whether or not the decision-making is inclusive of all the parties affected by it. The codes to the question regarding inclusiveness were determined before the data analysis. They are as follows:

i) **INCLUYH** -how the boards are inclusive

ii) **INCLUNH** - how the boards are not inclusive

The groups that possibly influence decision-making were identified through an analysis of the secondary data and documents, thus they were predetermined before

analysis. The board members were also asked if there were any other groups that influenced them. The responses were first analyzed using a simplified calculation in order to determine which group they thought were the greatest influence on their decision-making. The responses regarding the extent to which the identified groups influenced them and later how they influenced them were codified as follows:

i) **CMINFH** - how community members influence board decision-making
ii) **SHINFH** - how Saskatchewan Health influences board decision-making
iii) **HWINFH** - how service providers influence board decision-making
iv) **ININFH** - how interest groups influence board decision-making

The interview data also revealed responses regarding the specific influence of physicians. These themes were coded in the following manner:

i) **PHINFH** - how physicians influence board decision-making

APPENDIX C. APPLICATION FOR APPROVAL OF RESEARCH PROTOCOL

February 16, 1998

1. RESEARCHERS:

Renee Torgerson, Ph.D. candidate
Department of Sociology
University of Saskatchewan
Home: 653-5798
rcm119@mail.usask.ca

Supervisor:
Harley Dickinson
Department of Sociology
University of Saskatchewan
Work: 966-6930

2. TITLE: The Democratization of Public Institutions: The Case Study of Health Care Regionalization in Saskatchewan

3. ABSTRACT:

The Saskatchewan health care system recently underwent a restructuring process, mainly to ensure the sustainability of Medicare within an era of downsizing and privatization. However, this restructuring can be rooted within the dichotomies operating within modern political culture. One the one hand, the emphasis of regionalization is on increasing the bureaucratic efficiency of the system in order to control health care usage and costs. Yet, the ideal of bureaucratic management is juxtaposed with the democratization of the system, whereby its administration is more open to public input. It is within this new dichotomy that the structural site for decision-making, the district health board, is located. The goal of the reform is to facilitate the democratization of the Saskatchewan health care system vis-à-vis the district health board, yet at the same time, the process may only serve to entrench a more powerful, if more subtle, means of centralized control. It will be my task, then, to determine if indeed the district health board has emerged as the structural site for the democratization of health care services at the community level. Specifically, I will be seeking the answers to the following question: "Do the district health boards serve as the structural site for the democratization of health care services at the community level as perceived by the health board members?" The task of seeking the answers will be facilitated through the case studies of two Saskatchewan health care districts. The gist of the study will be on the possible structural changes to the authority system, rules and procedures and social relationships that have taken place within these two areas.

5. SUBJECTS: I selected the two districts as my sampling sites because of their location within the PECOS study area. The subjects were selected through a more purposive sampling technique because of their uniqueness and their small number.

To date, the districts have generally consented to the study. The agreement was made through communications with the districts through letter writing and by telephone. In both cases, I was contacting the administration of the health districts who then put my study on the board meeting agendas. The board members gave their general consent within these meetings.

6. METHODS/PROCEDURES: I will be utilizing the case study research design that will enable me to construct a model of Saskatchewan health from many different perspectives. Specifically, I will be using historical research on the districts, textual research of current files and documents put out both by the districts and by Saskatchewan Health, and a close and open-ended interviewing schedule. Both the historical and textual analysis stages can be done non-intrusively, as they are available from the library. At each stage, I will be analyzing the data through certain themes on two different forms of organizational structures - the bureaucratic structure and the democratic structure (see attached).

The interviewing schedule is pending since it will be the last stage of the study and will be dependent upon the information gathered from the other two stages. The interview itself will be about 30 to 45 minutes and will be tape recorded, unless the respondent indicates that he or she does not wish to be tape recorded.

7. RISK OR DECEPTION: I have been very aware from the inception of my study that roughly 2/3 of my research subjects are elected officials, and thus, special measures will be needed to ensure that there is no deception at all, or risk to their positions.

Indeed, I will seek to assure my subjects that this is not an evaluation of their activities; rather that I am interested in the structure of the Saskatchewan health care system itself. I will be taking the results back to them for their verification and validation and to ensure that they are not being individually identified in any way.

The one main risk within this study is that of identification, since my sampling base will be small and the interviewing procedures will be more open-ended, thus inviting possible political comments. The subjects will be notified of this possibility in my letter of informed consent.

The information collected by this study will be used towards a doctoral dissertation on the possibilities of democratization within public institutions. It is very possible that the district names will be mentioned in the dissertation, because I would like to provide a brief history of the two districts. I will also be using the information for possible presentations and publications, although in this latter instance, the names of the boards themselves may not be relevant and/or pseudonyms will be used. The respondents will be able to review the dissertation and the publications if they choose to ensure that they or their district as an organization has not been compromised.

8. CONFIDENTIALITY: To ensure that the problem as much confidentiality as possible, I will not be noting any distinguishing variables, such as gender, race, socio-economic background, etc. Moreover, the results will be reported through pseudonyms to protect their identity. When I am taking the analysis back to the health board members, I will ask them to address any concerns that they may have over identification. I will also not put the names of the respondents, nor any identifying marks on the interviewing schedule, and they, along with the tape recordings of my interviews will be locked in a filing cabinet either in my student office or at home. Five years after the material has been collected it will be destroyed. The five year waiting period is to ensure that I can verify the authenticity of the data.

9. CONSENT: The subjects will be given a letter of informed consent outlining my responsibilities and the possible risks (see attached). In it I have asked the subjects to send me a reply in writing stipulating that they either have, or have not understood my goals with the research. This will allow me to further address any concerns that my respondents may have.

10. DEBRIEFING AND FEEDBACK: To reiterate, the information generated by my study will be made available to the districts at the time of analysis for validation. As well, my subjects will be able to look over my results before I submit them to ensure confidentiality. This will ensure that the respondents can bring to my attention any information that identifies them so that it could be deleted or altered. The final results will be made available to the district members for their own use.

11. WITHDRAWAL: This study is strictly voluntary and the respondents are free to withdraw from the study at any time without providing a reason.

12. SIGNATURES:
1. STUDENT:
Renee Torgerson _____DATE _____

2. SUPERVISOR
Dr. Harley Dickinson _____ _____DATE _____

3. DEPARTMENT HEAD
Dr. Terry Wotherspoon _____ DATE _____

APPENDIX D: LETTER OF CONSENT

July 6, 1998

Dear Board Member ;

I am interested in studying your district as part of a overall research project on the restructuring of Saskatchewan health care services. I have been given a general consent by your district board, but I would like to provide you personally with an informed consent form which outlines my responsibilities and ethical guidelines as a researcher.

1. Contacts

You can call me or my doctoral supervisor Dr. Harley Dickinson at any time if you have any questions about my research agenda, issues about confidentiality, and foreseeable consequences:

Student Researcher: Renee Torgerson
Department of Sociology
University of Saskatchewan
Home: (306) 653-5798
Home Address: 542 Scissons Crescent
                Saskatoon, Saskatchewan
                S7S 1A5
E-mail: rcm119@mail.usask.ca
Supervisor: Dr. Harley Dickinson
Department of Sociology
University of Saskatchewan
Work: (306) 966-6930
I am also being funded by the Prairie Ecosystem Study (PECOS), Tri-Council Secretariat. Department of Soil Sciences, University of Saskatchewan. This is an interdisciplinary project looking at the question of ecosystem and community sustainability in the Palliser Triangle Region of southwest Saskatchewan.
Phone: (306) 966-8082

2. Abstract

I am interested in studying the possibilities of democratization within public institutions. The district health boards are an important case study since by their very structure, decisions have the potential to be made through participatory democracy. If there are structural obstacles to this ideal, then further exploration can be designed and policy regarding the autonomy of health boards can be developed. This type of study would benefit you since it would allow you to voice your concerns over how the current health system is organized and if it has led to, for instance, more flexibility in decision-making, more community participation and local control, or if the health boards are constrained by bureaucratic imperatives. I would like to repeat my statement that I am not interested at all in the job

performances of individual research subjects and will maintain this throughout my study.

3. Data Collection

The study itself will be carried out vis-à-vis an exploratory interview in the summer of 1998. The length of the interview could conceivably be 1 hour long according to your own personal responses. I will already have pre-tested the instrument with other Saskatchewan health board members to ensure a reasonable time length as well as the validity of my inquiries. The interviews themselves will be done at your convenience.

In order to ensure that I have compiled all the relevant material, I will be tape recording the sessions. If you do not wish to be tape recorded or have any concerns, then please let me know.

4. Confidentiality

I am fully aware that the majority of my research subjects are elected officials, and while I will do my best to ensure confidentiality by not using identifying variables (gender, race, etc.) and by using pseudonyms within my dissertation rather than real names, I cannot guarantee that your responses will be completely free from identification. This is due to the fact that my sampling base is small (about 24 respondents from 2 districts).

The information collected will be used towards a doctoral dissertation on the democratization of organizational structures. I will be using certain segments of my dissertation for publication purposes. I will also be identifying the health districts in my dissertation since their organizational histories are relevant to my analysis of structural change. You will, however, be made privy to my interpretations and results for verification and so that you will be able to clarify or delete any information in order to protect your identity. There will not be any identifying marks on the interview schedule itself so that there will be no way to connect you with your responses.

I will keep the interviews securely stored at the university for the requisite minimum five years after which they will be destroyed. The five year period is for future authenticity purposes as required by the University of Saskatchewan research guidelines. For instance, other researchers may require reasonable proof of my interpretations and results.

5. Withdrawal

You are free to withdraw from the study at any time, and I will seek to inform you of any issues that arise which may affect your decisions to continue in the research, including my use of the data for publications.

Please feel free to contact me at any time about the study if you have any concerns or questions. I would also like to ask you to inform me through writing that you have received this form and that you do (or do not) understand its contents. To more easily facilitate this, I have enclosed a form which signifies that you have

received this letter as well as a stamped envelope. I would greatly appreciate it if you could return this form as soon as possible.

I (please print your name) _____, have received and read the consent sheet provided by Renee Torgerson from the University of Saskatchewan.
I understand that participation in the study is voluntary and that I will be able to withdraw at any point without penalty or loss of services.

Date: _____

Signature: _____

Again, if you have any questions or concerns, please feel free to contact Renee Torgerson or Harley Dickinson.
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