

DISCOURSES AND PRACTICES OF  
HEALTH SYSTEM REGIONALIZATION IN SASKATCHEWAN:  
DOMINANT, CONTESTED AND ABSENT THEMES

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By

Kelly Chessie

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## ABSTRACT

Policies of health system regionalization with agendas of increased public participation were significant components of Saskatchewan health reforms of the 1990s. Regionalization entailed both devolving and centralizing powers from provincial ministries and local facility boards to newly created regional boards comprised of local community members who would now be in charge of planning and delivering local health services. An under-considered area in policy studies is the interpretation and agency of central actors charged with taking government announcements and public policy amendments and enacting these into day-to-day practices. This dissertation explores this interpretive space.

Based on interviews with 11 Health Authority Board Chairs, 8 health region CEOs, 8 Ministry of Health officials, and 5 members of Advisory Networks, this research examines how these actors framed and practiced “regionalization” and “public participation” policies. Drawing on a discourse analysis utilizing NVIVO software, my analysis revealed that the central actors framed their interpretations and practices of regionalization within technocratic logics: regionalization and public participation policies were interpreted and constructed as routes to efficient and effective services. Although population health logics framing the policies in terms of their empowerment potentials were called on early in the reforms, these logics no longer appear in the discourse and practices. Democratic traces and concerns of local representation and accountabilities persist. While largely accommodated and hybridized within technocratic framings, sites of democratic-technocratic contestation remain.

In keeping with broader transformations, publics are increasingly called upon to participate not as citizens but as responsible patients and families, with individualizing patient, client, and consumer positions being prioritized over collective positions of communities and populations. Technical accuracy appears to take precedence over public accountability and engagement. Experts make decisions, with input provided by reflexive publics, and the ultimate goal is an efficient system.

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Every day things disappear

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## **LIST OF ABBREVIATIONS**

CAN	Community Advisory Networks
CEO	Chief Executive Officer
RHA	Regional Health Authority; the Board of Directors or Board of Governors, appointed by the Ministry of Health to oversee the work of the health region.

## CHAPTER 1: INTRODUCTION

### 1.1 Overview

This study of health system regionalization explores the discourses and practices of actors central to the regionalization model most recently practised in Saskatchewan. Health system regionalization was a governance innovation that during the health reforms of the 1990s, swept across Canada. At its most basic, regionalization saw provincial systems dissolve local hospital and facility boards, centralizing their powers and authorities to newly created regional boards, while simultaneously decentralizing some planning and delivery responsibilities from the central, administrative states down to the newly created sub-provincial regions. The newly created regions, overseen by governance boards comprised of local citizens, were charged with planning, delivering, and governing local health services. This practice of formally introducing members of the public and community into the governance structure of the provincial health system, led regionalization to be cited the most significant reform to health care since the introduction of Medicare (Lomas, 1996; Lomas, Woods and Veenstra, 1997). Despite this claim, regionalization as a formal vehicle for civic engagement, and community and public participation in health system governance, policy, and decision-making, has received relatively little critical evaluation and consideration, leaving much to understand about this potentially radical innovation in health system governance models.

While government announcements of regionalization may have offered the potential to institutionalize public participation and community engagement within the governance structure of a provincial health system, the reality is that in between the highly scripted government announcements (laden with rhetoric and ideology) and the

everyday discourses and practices that eventually result from these announcements, lay the interpretations and agency of actors. How these actors collectively understand these public policies and announcements and, in turn, fashion practices from them, is a relevant and yet under-examined step in analysis of public policies in general, and regionalization and public participation policies in particular. The current research explores this space between the discourses and practices of a group of central and influential actors who were directly involved in the implementation of a set of regionalization and public participation policies introduced within Saskatchewan's provincial health system in 1992 and then amended in 2001.

This research was designed to explore the ways in which people on the front-line of these potentially innovative announcements came to frame and practise the initiatives. The interpretations and agency of actors does not occur in a vacuum, and the social forces within which they operate come to influence (and be influenced by) their interpretations and actions, their discourses and practices. Understanding these interpretations offers insight, not only into these policies, but also into the broader socio-cultural and political worlds in which the actors are embedded; exploring one can reveal details of the other.

This research was conducted within an epistemological framework that views discourses as reflective and productive (Bazerman & Paradis, 1991; Fairclough, 2001; Foucault as cited in Smith, 2005, p. 18; Wodak & Meyer, 2001). Such an approach recognizes the role discourse plays in shaping the material world (e.g., institutions and structures) and the role the material world plays in shaping discourses. Given this mutually constitutive relationship, it is important to consider significant discourses of our times, asking what it is they reflect from and (re)produce in our socio-cultural worlds.

Typically, lifeworld struggles within the field of health care and medicine are considered and analyzed within the context of patient-provider interactions (e.g., Batt, 1998; Kaufert & O’Neil, 1998; Heritage & Maynard, 2006). With the widespread introduction of regionalization and public participation policies, however, a new interface has opened—one situated at the seams of the central-administrative state<sup>1</sup> and the public spheres and everyday lifeworlds of people, publics, and communities. The current research attends to this interface, and is guided by three general objectives:

1. to explore how central actors frame, understand and practise regionalization, paying particular attention to the rationalities and logics called on by these central actors through the identification of dominant, residual and emergent discourses (Brodie, 2008; Clarke, 2007; Williams, 1977).
2. to explore how these actors frame and interpret public participation within health system governance models, again paying particular attention to the rationalities and logics called on (and the dominant, residual and emerging elements within) to contextualize and explain public participation.
3. to consider plausible effects of these interpretations and practices on the roles and functions of the actor group within the governance model and their impact on the interface between lifeworlds (of patients, publics, citizens, and communities) and administrative systems.

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<sup>1</sup> In the context of this research “the state” is represented by (a) the provincial Ministry of Health (and all its related staff, programs and services), (b) the Deputy Minister of Health, through whom the Ministry reports to the Minister of Health, (c) the Minister of Health, an elected Member of the Legislative Assembly of Saskatchewan, appointed to the post by the Premier and the Government of Saskatchewan, and (d) the elected Government of Saskatchewan. The state is thus a nexus of political-administrative institutions, structures, relationships, people, practices, powers, and authorities.

The discursive frameworks, in which public policies are conceived, established, and practised in this province and in this public sector, are real and effecting and have definite influences within the boundaries of this case study (i.e., health reform in Saskatchewan, Canada from the early 1990s to the recent past). Logics and rationalities<sup>2</sup> become ways of seeing the world, carrying with them the ability to privilege certain discourses, vocabularies, ideas, truths, and subjectivities (Brodie, 2008; Clarke, 2007; Dean, 1999; Foucault, 1991; Miller & Rose, 1990; Rose, 1999; Williams 1977). Of relevance to the current research, health system regionalization and public participation have often been framed by advocates and scholarly writers as routes to more efficient and effective services (i.e., within a technocratic logic), stronger public spheres and democracies (i.e., within a democratic logic), and empowered publics and healthy communities (i.e., a population health logic). These framings prioritize certain ideas and practices while excluding others.

As health system reform is a significant and seemingly perpetual public policy issue in this province (and country), pausing to take time to consider and interrogate the discourses and ideological frameworks within which the reforms are embedded, considering what it is they are reflecting and (re)producing (solidifying and making (im)possible), is time well spent. Equally important is the interrogation of absences and gaps in the meanings, interpretations, and practices, with consideration given to those understandings and practices that are being marginalized and erased.

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<sup>2</sup> Logics, rationalities, mentalities, and frameworks are used interchangeably in this dissertation to refer to ways of seeing the world, that wax, wane, and morph, privileging and marginalizing ideas and practices as they do (Brodie, 2008; Clarke, 2007; Williams 1977). Logics and rationalities become apparent in a variety of ways; of primary relevance in this dissertation is their appearance through discourse and everyday practice.

Before proceeding further to the specifics of the current research, it is necessary to set the stage for this project and review some of the socio-historical contexts within which the work was conceived and conducted. These details help in better understanding the material realities and organizational structures that contributed to the meanings, interpretations, and practices of both the researcher and the central actors studied.

## **1.2 Regionalization in Canada: Macro-Level Contexts<sup>3</sup>**

Amidst an ethos of fiscal restraint and retrenchment, the 1980s and 1990s saw western nations questioning the goals of their welfare states including health systems and publicly funded care (Crichton, Robertson, Gordon & Farrant, 1997; Drache & Sullivan, 1999). As costs and service demands climbed and tax revenues fell, and as questions of sustainability and imbalanced resource-allocations amongst public sectors grew, governments introduced a wave of reforms to restructure and rationalize health care delivery (Wetzel, 2005).

Attention to health care was not new to Canada. From the early days of Medicare and the struggles surrounding efforts to introduce insured hospital and physician services to residents of Saskatchewan and Canadians, health care has been a prominent element in provincial and national public policy. Echoing the moves of the international scene, and situated within broader transformations of the welfare state, Canada and her provinces turned attention to health systems, and governments announced commissions and reviews to comb the systems for efficiency gains. Many themes emerged within the resulting reports including the adoption of a broader definition of health, increased attention to illness prevention and health promotion in lieu of a more traditional curative focus, and

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<sup>3</sup> Parts of this sub-section and the next were first published in Chessie (2010). Reproduction here is with the kind permission of the Canadian Plains Research Centre.

shifts from institutional-based to community-based care where feasible (Mhatre & Deber, 1992). Another theme was a call for public involvement and community engagement in health system planning and governance (Mhatre & Deber, 1992; Crichton et al., 1997). Citing population health and community development logics (such as the Ottawa Charter and the Lalonde Report), calling on legitimization needs and increased public accountability, and referencing responsible citizenship, the reports recommended increased public participation as a partial reform strategy (e.g., Hyndman, 1989; Murray, 1990; Nova Scotia Commission on Health Care, 1989; Premier's Council on Future Health Care for Albertans, 1989; Rochon, 1990; Seaton, 1991).

On the heels of the reviews, nine provinces and the Northwest Territories introduced or reintroduced<sup>4</sup> policies to regionalize their health systems. These policies, while differing from province to province in the specifics, devolved varying levels of power from provincial ministries down to newly created, sub-provincial authorities, each overseen by a governance board comprised of local community members (Kouri, Chessie & Lewis, 2002). The announcements of devolution were accompanied by a centralization of powers from the many independent health facility and health service boards that had been operating throughout the communities. With their elimination, their powers and responsibilities were centralized up to the newly created regional authorities (Lewis, 1997; Lomas, 1999; Rasmussen, 2001).

Publicly stated intentions for regionalization included more than structural changes, or changes in the organizational forms of the governance models (e.g.,

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<sup>4</sup> Public policies of health system regionalization and community involvement were not entirely new when they were introduced in the 1990s as Saskatchewan had endorsed these notions after Sigerist (1944) and a health region existed in the Swift Current area from the mid-1940s to the 1990s (Feather, 1991; Houston, 2002; Taylor, 1987). This first round of regionalization and public participation is not the focus of the current study.



centralization up, decentralization and possibly devolution down, and appointed or elected boards). These announcements were also embedded within stated intentions for substantive, functional changes, as governments positioned regionalization as a means not only to enhance the efficiency and effectiveness of the system, but as a means to formally introduce citizens and public participation fora into the health system governance structure. In this way, regionalization was to help make the system reflexive and accountable to local communities and the publics they serve. This shift to include publics in health system governance (along side traditional players such as health care providers, system administrators, policy-makers and governments) led regionalization to be cited as the most radical reform to Canadian health care since the introduction of Medicare (Lomas, 1996; Lomas et al., 1997).

Within a decade of these announcements, a subsequent wave of health reform swept across Canada and most governments adjusted the governance structure by reducing the number of regions, altering board compositions (e.g., some provinces eliminated elections in favor of appointments), and clarifying accountabilities and authorities between regions and central governments (e.g., Clair, 2001; Fyke, 2001; Mazankowski, 2001; Saskatchewan Health, 2001).

At the time of this writing, another wave of reform has crested in Canada: Prince Edward Island has disbanded its authorities (Prince Edward Island, 2006); New Brunswick has merged its eight regions to two (New Brunswick, 2008); and Alberta has centralized its nine boards to one (Liepert, 2008).<sup>5</sup> Manitoba, on the other hand, has

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<sup>5</sup> Another significant change was that the new super-board was composed of individuals allegedly selected for their professional skills and credentials (Alberta Health, November 2008). Of particular significance, here, is that their connections to and ability to represent local communities and needs was not highlighted

received a favorable review of its health regions that included a recommendation to consider a more complete devolution of authority (Gray et al., 2008). In 2006, Ontario, the only Canadian province to have forgone regionalization, announced local health integrated networks, or LHINS, which may indicate this province's tentative step towards its own form of regionalization (Government of Ontario, 2006). In Saskatchewan, there is speculation that the form and function of its Regional Health Authorities (RHAs) will be reconsidered in the wake of its recent "Patient First Review" (Dagnone, 2009). Table 1 summarizes some of the major structural milestones in Canada's more recent regionalization history. Let us turn to the specifics of the Saskatchewan context, attending to the two most recent regionalization models introduced and practised here (i.e., the 1992 introductory model and the 2001 amended model).

### **1.3 Regionalization in Saskatchewan: Meso-Level Contexts**

In 1992, Saskatchewan became one of the first Canadian provinces (in this contemporary era of regionalization) to adopt a regionalized model within its provincial health care system. As part of a broader package of reform, the Province (under a then newly elected New Democratic Party government) eliminated some 400 independent health facility and service boards and replaced them with 32 sub-provincial districts each overseen by a mixed group of elected (two-thirds of the total board) and appointed (one-third of the total board) community members. This group, referred to as a District Health Board (DHB), served as the board of directors for the health district, assuming responsibility for the planning, delivery and governance of district services

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in their appointments. This marks a significant shift in the discourse of health board composition in Alberta and Canada, and marks but one way in which the public policy is changing in both form and function.

Table 1. Regionalization in Canada: Selected Features and Key Dates<sup>6</sup>

	Years	Highlights of Regional Systems
Early trials	1940s	In SK, after the Sigerist Commission, the Province encouraged regionalization and from the 1940s to the 1990s one region, the Swift Current health region, operated in the southwestern area of the province. Overseen by a board comprised of community members, it was charged with overseeing, planning and delivering care to residents of the region.
	1975	ON would be the sole province to not regionalize in the 1990s, but did introduce (in 1975) a system of 18 advisory District Health Councils.
Rapid adoption	1988-97	NT operated with a system of 7 health and social service authorities, comprised of appointed members, responsible for the planning and delivery of health and social services for the territory.
	1989-92	QC created 18 regional health and social service areas overseen by elected (via stakeholder groups) board members.
	1992	SK announced provincial regionalization, forming 32 health districts and 1 northern health authority. After initial appointments, board members were elected (two-thirds) and appointed (one-third) and were responsible for planning and delivering local health services.
		NB introduced 8 Hospital Corporations (HCs) with appointed members responsible to plan and oversee hospital services.
	1993-94	PE introduced system of 5 RHAs, with mixed elected and appointed members responsible for a range of health, and social justice services.
	1994	NF introduced a system of 14 boards (8 institutional, 2 community, 2 integrated) with appointed members, responsible for the planning and delivery of health services, with a division along community and institutional lines.
		AB introduced a regional system with 17 RHAs. Members were appointed and were responsible for planning and delivering local services, excluding mental health and tertiary care (a provincial committee would oversee these services).
	1994-96	NS introduced 4 regional boards (with 34 community councils to advise them) and began devolving authority to boards to have them manage and deliver hospital-based and mental health services. Boards were comprised of Council members. Two Provincial Councils would set strategic plans and ensure coordination across the regions.
	1997	BC introduced a regionalized system with 11 Boards, 34 Health Councils and 7 Health Services Societies. Members were appointed and were responsible for planning and delivering local services.
	1997-98	MB moved to regionalization with 12 RHAs, and appointed members responsible for health services.
Reform models	2001	BC restructured its boards and councils into 5 Regional Authorities and 1 Provincial Authority.

<sup>6</sup> Adapted and updated from Kouri et al., 2002.

		NS moved to a system of 9 District Health Authorities with their own Community Health Boards. Authority members are appointed with input from the Boards.
		QC restructured its governance system so that boards were fully appointed and boards and CEOs were accountable jointly to the Ministry and the local. QC now has three levels of governance: (a) central (the Ministry who sets provincial priorities and policies); (b) regional (who are responsible to coordinate and deliver regional services, enacting regional services according to need and priority, and ensuring involvement of the population in the governance of the system); and (c) local (all partners at the local who are involved in delivering health and social services to the population). As well, the Ministry has 14 advisory boards with whom it meets to collaborate on mutual agendas.
	2001-02	In SK, districts were replaced with 12 RHAs and 1 northern authority, elections were eliminated, and Community Advisory Networks were introduced as a route for local input into governance and decision-making.
	2001-04	AB held elections, moving to a system of mixed elected and appointed boards and reduced the 17 RHAs to 9.
		NB replaced HCs with 8 RHAs responsible for the broader range of health services (not just hospital care). Elections were held in 2004 to shift boards from appointed to mixed elected and appointed boards.
	2002	PE amalgamated 2 RHAs and introduced a Provincial Health Services Authority, responsible for secondary and acute care services.
	2002-03	NT moved to 8 RHAs for the territory.
		MB amalgamated two RHAs, reducing their total number to 11.
	2004	NF amalgamated to 4 Regional Integrated Health Authorities charged with overseeing care across the continuum of sectors.
Recent moves	2006	ON introduced LHINs with formal authority to fund and make decisions regarding local services.
		PE disbanded its RHAs.
	2007	MB received a positive external review of regionalization that included recommendations to devolve further authority to the RHAs.
	2008	AB dissolved the 9 RHAs, the Mental Health, Cancer and Alcohol and Addictions Boards and formed one provincial board comprised of appointed professionals and experts.
		NB amalgamated its 8 RHAs to 2 with 1 provincial health council to ensure local input. Members are all appointed.
	2009	SK received its “Patient First Review” that included a review of administrative efficiencies. Cognizant of possible effects of another wave of reform, the Commissioner did not recommend changes to the governance structures, but did encourage consideration of future changes to streamline and integrate the system. Speculation thus continues as to how long RHAs will exist with their current form and functions.

(Saskatchewan Health, 1992c). In this model, public participation would be realized through (a) the elected and appointed community members serving on boards, and (b) the community consultations and formative processes that preceded and contributed to decisions regarding the geographical boundaries of the 32 districts. Communities were, to varying and contested degrees, involved in the decisions as to what district they would join. As these governance reforms took place alongside other reforms (such as the closure or conversion of over 50 small, rural hospitals and significant reductions in federal transfer payments to the provinces), regionalization was critiqued and questioned by the opposition parties, media, publics, and communities.

In 2000, the New Democratic Party Government (newly re-elected for its third term as a minority government that evolved into a majority as elected members of the Liberal Party joined the NDP) appointed a Commission on Medicare to review the health care system and make recommendations for long-term sustainability of the public system. The Commission's recommendations included: (a) amalgamating districts to reduce the overall number and thereby increase the size of each region, and thus, theoretically the resources available to each (e.g., fiscal, population served, staff and management, etc.); (b) clarifying the roles and responsibilities of the health boards and the provincial ministry; and (c) monitoring voter turnout for elections and, if turnouts remained low, considering alternatives (e.g., moving to fully appointed boards) (Fyke, 2001).

After the Commission reported, and after a series of its own hearings, the then Minister of Health, John Nilson, announced amendments. Among the reforms, the 32 districts and their governing boards were amalgamated into 12 regions with fully appointed board overseeing each. These boards, now titled Regional Health Authorities

(RHAs), were to plan, manage, and deliver local services. To compensate for the shift to fully appointed boards and the reduction from 32 DHBs to 12 RHAs, the government announced Citizen Advisory Networks (CANs). The CANs were formal (albeit, in practice, optional) structures to help link community members with health regions and their boards (i.e., RHAs) and to support broad community involvement in the setting of plans and priorities (Saskatchewan Health, 2001).

This 2001 model locates public participation opportunities not within the RHAs themselves (even though these boards are comprised of community members and are thus sites of public and community engagement), but instead within the CANs, a new structure one-step removed from the RHA and decision-makers. In comparison, the 1992 announcements clearly located public participation opportunities within the boards themselves (Saskatchewan Health, 1992c). This shift is significant and marks but one way in which the policy practices of regionalization and public participation begin to change in substantive function, not just formal structure.

In addition to the structural changes (i.e., changes to the form of the boards) announced in 2001, there were also marked changes in the way regionalization and its concomitant logics of local participation were articulated. As argued previously (Chessie, 2010), the government-issued publications that documented the 1992 announcements were replete with rhetoric calling for the greater involvement of and greater control by citizens and communities over local services. In this way, the documents announcing the 1992 reforms resonated with what I refer to as population health logics (e.g., public participation, community involvement, and local control is empowering and thus health promoting) and democratization frameworks (e.g., democracy is strengthened when

citizens with political rights and capacities participate, decide, and guide public services). Better health and more efficient and effective health care systems would come from local people, with local knowledge, exercising local control; district health boards were referred to as sites of community empowerment, engagement, governance and accountability (Saskatchewan Health, 1992c). In other words, citizens and communities were to be actively involved in planning and overseeing *their* system.

The 2001 documents stepped away from democratic and population health arguments to call more on what I refer to as technocratic logics. This new direction argued that health system efficiency and effectiveness would come via evidence-based decision-making and centralized planning, supported by patient “input” and advice when needed by decision-makers. That is, patients’ opinions were solicited as consumers of health services, but these processes for their input were not positioned as structural attempts to empower citizens (as per population health or democratic arguments) by enabling them to exercise community control. While perhaps correcting for the overly romantic version of community involvement embedded in the 1992 texts, the 2001 text inverts the prior model to reflect technocratic understandings of decision-making and system governance, prioritizing experts and traditional decision-makers. With the 2001 policies, a switch has been made, from “hands on” and controlling local boards with elected ties to community, to boards that regulate, monitor, and evaluate, comprised of appointed members (who require connectivity to their local areas via CANs, not political campaigns, elections, and representation). There is no mention of population health strategies of empowering and engaging local communities, nor of exercising the political rights and capacities of citizens. Thus, a contradiction emerges in the 2001 amendments:

they appear to value linkage between citizens and the health system through CANs and by having community members serve as governors of their regional authority, but the explicit references so visible in the first-wave announcements to meaningfully involving communities as partners, through community-based decision-making, are gone.

The new discursive framings signaled a shift in direction for health boards, one that positioned them more within technocratic rather than democratic or population health logics while reducing public participation through CANs, structures which were not obligatory under the new legislation. Indeed, observers have suggested that regionalization was perhaps not the radical reform first thought and instead was the driver of incremental, gradual change (e.g., Casebeer, 2004; Lewis & Kouri, 2004). Commentators have also questioned commitments to the public participation intentions of the first wave of regionalization across Canada, suggesting that recent iterations substitute health system accountability to publics and communities with health region accountability to governments (Lewis & Kouri, 2004).

#### **1.4 The Present Study**

In discourse analysis, texts (both written and spoken) are seen as access points to larger social, structural, and cultural features that influence what we write and say (Smith, 1986, 1990, 2005). While changes in discourses and framings of the formal and highly scripted government announcement texts can be seen from the 1992 introductions to the 2001 amendments, it is not known the degree to which these shifts have come to be reflected in the meanings and interpretations of the actors themselves who enact the policies. Their interpretations, as reflected at least in part through their informal



discussions and texts (i.e., their discourses), are productive and stabilizing forces worthy of scrutiny and consideration (Foucault, 1991).

The current study is oriented toward understanding these interpretive spaces and day-to-day practices; it moves from an analysis of the formal and highly scripted announcements to the less formal and scripted texts of actors, whose job, in part, has been to interpret these reforms and policy announcements, and then construct them into practices. In particular, the current research explores the discursive texts captured in 32 semi-structured interviews, completed with a large group of actors (11 RHA Chairs, 8 health region CEOs, 8 senior Ministry of Health officials, and 5 CAN members). I was intrigued to explore *their* meanings, *their* interpretations, and *their* practices of “regionalization” and “public participation.” These views, however, are not formed in a vacuum, but are forged in relationship between and among the central actors who are themselves located in socio-cultural, administrative and political structures, practices and conceptualizations. At times, these relationships are relatively seamless and harmonious; at other times, they are contradictory or conflicting.

This study is not a historical reconstruction of the changing models and practices of regionalization, asking what changed between the 1992 and the 2001 model and positing hypotheses as to why. Nor does this study contribute to the development and refinement of regionalization and public participation policies and practices. Rather a goal for this research was to approach the field, the discourses, the meanings, interpretations, and practices, and the logics reflected and reproduced therein, as objects of critical inquiry; that is, the particularities of the language used to construct the various logics invites us to enter into the habitus (Bourdieu, 1977; 1984) of the central actors, as

well as providing an understanding of what might have been—given the existence of competing logics (Calhoun, 1995, p. xviii). Thus, “critical” not only denotes rigorous examination; it also implies that the researcher considers how social forces can align to mitigate agency, thereby limiting the ability of actors to shape the very decisions that affect their lives (Kincheloe & McLaren, 2005).

### **1.5 Overview of the Dissertation**

This dissertation explores the interpretations and practices of central actors involved in enacting regionalization and public participation policies within Saskatchewan’s health care system. To accomplish this task, I have written six chapters. The present chapter introduced both the study and the socio-historical contexts within which the research was conducted, detailing how health system regionalization with its concomitant theme of public participation was introduced, and in very broad terms, how it was practised in this province from the early 1990s to the present.

Chapter 2 turns to the academic literature on health system regionalization and public participation in health system governance and decision-making. Herein, I review literature, attending to what it is known about these public policy experiments while also considering the ways in which academic writers have positioned and theorized these innovations. There are at least four recurring positions that appear within this literature, relating to the logics and guiding frameworks with which these policy innovations are discussed: (a) a population health logic (i.e., regionalization and public participation are good for our health); (b) a democratic logic (i.e., regionalization and public participation are good for democracy); (c) a technocratic logic (i.e., regionalization and public participation are good for the health care system); and, (d) a governing-mentality (i.e.,

policies and notions of regionalization and public participation are but adaptations in our modes of governing and represent new ways of regulating conduct). After describing these logics in more detail, providing examples of each and anchoring them within broader theoretical frameworks, I argue that a gap exists between these scholarly discourses of regionalization and the ways in which they are enacted in the everyday life of the participants involved. In particular, the central actors – those individuals who interpret policy announcements and fashion practices from them – are under-represented in the academic literature. There is a paucity of research considering what regionalization and public participation discourses, framings, and practices of these actors reveals about their social and political worlds.

This guiding question sets the stage for the dissertation. Before turning to the specifics of the study, however, Chapter 2 also includes a review of two semi-competing, semi-complementary theoretical frameworks within which I approach the discourses and practices of the central actors—the social theory of Jürgen Habermas, with his normative notions of lifeworlds helping to shape and program political-administrative systems, and the work of Michel Foucault, with his attention to lived practices, discourse, and “governing mentalities.” For many readers, calling on the work of these theorists simultaneously poses an untenable position (e.g., Ashenden & Owen, 1999); to others it is advantageous and yields strategic knowledge (e.g., Biebricher, 2007). This discussion will be extended in Chapter 2.

Having set the stage for the research, Chapter 3 outlines epistemological and methodological considerations influencing this research (i.e., that discourses matter since they both shape and reflect the socio-cultural and material worlds), as well as its specific

methods (i.e., sample, data collection procedures, data, and methods of qualitative analysis). I completed semi-structured interviews with 11 RHA Chairs, 8 health region CEOs, 8 senior Ministry of Health staff and officials, and 5 CAN members. These recorded interviews and their transcriptions are the central data source for this study.

Chapter 4 attends to these central actors' discussions of regionalization and in particular their interpretations of the roles and functions of the RHAs and of three other actor groups central to regionalization and the governance model (i.e., the health regions, the Ministry, and the CANs). Analysis reveals rich descriptions of a technocratic logic that pervades and dominates the central actors' practices and interpretations. Out of these technocratic interpretations and practices, a new form of governance board is constructed, one that functions as an administrative overseer operating on behalf of the administrative state (as opposed to a governance board operating on behalf of publics and local communities). These constructions are rooted in formal structure (e.g., legislation and policy) and informal, day-to-day practices.

Regionalization and public participation policies have been interpreted and practised within complex contexts, however, and as would be expected, competing and overlapping interpretations and practices co-exist. Thus, while a technocratic logic appears as a dominant interpretive framework, democratic traces (as defined in this study) also appear and Chapter 5 explores these traces. In some cases, these democratic elements are accommodated by the overarching technocratic logics. In other contexts, these democratic elements appear to have hybridized with the technocratic logics and actors shift seamlessly, back-and-forth, between the two. In yet other contexts, these traces appear to counter the technocratic logic and to exert subtle tension to its

dominance. In particular, there appears a disjuncture between the technocratic means and the occasional democratic ends that appear in *some* of the interpretations and practices of *some* actors. As well, there exists competing interpretations as to the expected knowledge contributions of board members, wherein some actors posit them to be expert contributors offering technical knowledge and skills to the governance role, while others posit them as lay members of the regions, offering community connections and knowledge of lifeworlds. While technocratic logics in the discourses and practices of regionalization and public participation appear to be waxing alongside waning democratic elements, earlier population health logics are now absent. As government texts dropped heady reference to empowered, self-directed communities and publics, so too, it would appear, have the interpretations and day-to-day practices of central actors.

Chapter 6, the concluding chapter, considers the implications of these findings for the social worlds within which we live, and the policy worlds within which these governance innovations are conceived, interpreted and practised. I argue that the reframing of public roles from “empowered citizens” to “consulted users” to “satisfied customers” has important implications, as does the (re)construction of RHAs from local community members steering, directing and governing local services to board members who liaise with and enact Ministerial priorities. The politics of renaming (Dobrowolsky & Jenson, 2004; Lister, 2000) is real and affects how public policy is framed and what subjects and interventions are appropriate. This chapter also reflects on the complementary potential of Habermasian and Foucaultian approaches. These seemingly opposing theoretical perspectives proved a workable and beneficial combination that

supported a dual focus on everyday micro-practices *and* normative concerns for lifeworlds-system interactions.

Having detailed the broad research questions and the organizing plan for this dissertation, let us turn now to Chapter 2 and the scholarly literature on regionalization and public participation, to review what is known about these policy innovations, to consider how it is that these policies are talked of, and to examine the logics commonly embedded within the literature. Two social theoretical frameworks will also be reviewed, within which the interpretations and practices of these policy innovations will be considered.

## CHAPTER 2: LITERATURES AND INTERPRETIVE LENSES

### 2.1 Overview

Four bodies of literature were explored to inform the present research. The first was a review of the Canadian literature on health system regionalization. Within this, I considered what has been evaluated and how, and what has been established in terms of the efficacy of these policy innovations. I also attended to how writers theorized and argued regionalization, and the types of questions and concepts brought to the research.

The second body of literature consisted of a review of the literature on public participation in health system decision-making in general (i.e., not only participation rooted in board membership and involvement in governance-level decisions). Here, I attended not only to what has been considered and found when evaluating these public participation initiatives, but also how these innovations were approached and positioned, and the concepts of public participation considered.

As I was beginning my research and reviewing the literature, I came to hear different arguments and intentions underlying the reasoning for health system regionalization and public participation. Four broad themes emerged within this discourse. In particular, there appeared what I have labeled (a) population health logics (i.e., regionalization and public participation policies and practices are good for health), (b) democratic logics (i.e., regionalization and public participation policies and practices are good for democracy), (c) technocratic logics (i.e., regionalization and public participation policies and practices are good for the health care system) and, (d) a governing-mentality (i.e., “regionalization” and “public participation” are contemporary adaptations in our modes of governing, and represent but new ways of regulating the

conduct of individuals and populations). The first half of this chapter will provide an overview of these bodies of literature, and a detailed examination of these four themes.

In addition to the scholarly literature specific to regionalization and public participation, I also reviewed the work of two social theorists, each of whom provided valuable lenses through which to consider these policy innovations. Although there are unlimited lenses one could choose, the tensions that emerge in the literature—between on the one hand a cautious optimism for increased public participation in health system governance and decision-making and, on the other, a skepticism and concern with the mentalities and practices developed therein—are ably captured by the works of Jürgen Habermas and Michel Foucault. Following from the social theory of Habermas, regionalization and public participation can be understood as having democratizing potentials, wherein lifeworlds and civil society organizations, through deliberation, come to form common values that then steer the decisions and actions of the political-administrative system. This lens focuses the optimistic eye to the positive potentials of regionalization, public participation, and citizen engagement in governance models and decision-making fora while creating a normative ideal against which to consider system-lifeworld interfaces. This focal point, however, can simultaneously blur our focus and lessen our ability to see front-line, everyday practices and realities (as opposed to mere normative potentials). These practiced realities, rife with power struggles and demonstrations of “how” (as opposed to “why”), come more clearly into focus when viewing these policy innovations through a Foucaultian lens. This lens focuses a skeptical eye to the day-to-day practices, meanings, interpretations, discourses, and mentalities that accompany significant shifts in governance modes. Through this lens, the “capillaries of



power” that seed and feed through these new governance models and public policy innovations can be considered. The second half of this chapter reviews the literatures outlining the frameworks and lenses offered by these two theorists.

## **2.2 The Regionalization Literature**

### **2.2.1 Introduction**

Despite its early label as the most significant reform to health care since the introduction of Medicare (Lomas, 1996; Lomas et al., 1997), there has been surprisingly little evaluation of regionalization, and even less critical consideration of this policy initiative, particularly in relation to the insertion of communities and publics<sup>13</sup> into the governance model and in terms of the democratic and public accountability potentials. While critical evaluations are rare, factual descriptions and overviews are more common, as are informed opinions and commentaries as to the potential negatives and positives of regionalization (e.g., Adams, 2001; Bickerton, 1999; Church & Barker, 1998; Church et al., 2002; Crichton et al., 1997; Davidson, 2004; Davis, 2004; Denis, Contandriopoulos & Beaulieu, 2004; Dorland & Davis, 1996; Flood & Archibald, 2005; Konkin, Howe & Larsen Soles, 2004; Lewis, 1997; Lewis & Kouri, 2004; Lomas, 1996, 1999; Marchildon, 2005; Marchildon & O’Fee, 2007; Mhatre & Deber, 1992; O’Neill, 1992; Rasmussen, 2001; Reamy, 1995; Tomblin, 2004). There are also a number of empirical evaluations attending to structural changes (i.e., changes in board formation, such as the number of boards and their specific compositions) and administrative goals of regionalization (e.g., service shifts, efficiencies, and organizational changes within regionalized systems),

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<sup>13</sup> Or at least the insertion of *some* communities and publics; for a literature raising questions as the actual degree of representation of publics appearing in these venues, see for example Chessie (2009), Church and Barker (1998), Side and Keefe (2004), and Wharf Higgins (1999).

while largely ignoring more substantive changes (i.e., changes in function), and potentials related to broader questions of governance models, public participation, and community engagement (e.g., Benoit, Carroll & Millar, 2002; Casebeer & Hannah, 1998; Casebeer et al., 2006; Hanlon, 2003; Hanlon & Skedgel, 2006). Most of the evaluations considering these substantive goals have been historical and conceptual reviews, informed opinions, and commentaries that, while interesting and occasionally provocative, have added little empirical evidence to the field (Bickerton, 1999; Church & Barker, 1998; Church et al., 2002; Davidson, 2004; Flood & Archibald, 2005; Fooks & Maslove, 2004; Lewis, 1997; Lewis & Kouri, 2004; Murphy, 2005; O'Neill, 1992; Rasmussen, 2001). There have been exceptions, and these are discussed below.

### **2.2.2 Canadian Studies of Regionalization**

Quebec was one of the earliest provinces to experiment with governance models that inserted community representatives onto boards previously comprised only of health care professionals and administrators. Evaluations of these early experiments provided mixed results. Although there was some indication of meaningful involvement of community members in the early stages of establishing new health centers, community members were then unable to exert substantial influence over the health centre once it was established and running, and they appeared to lose their influence to health center staff (Godbout, 1981). Variables that buoyed community member influence included privileged class status, the ability to mobilize people and resources outside the health centre, a meaningful link to the day-to-day functioning of the centre, and some recognition by staff and broader community of their legal authority as a board.

Eakin (1984a, 1984b), in an evaluation of community participation on Quebec hospital boards, showed that despite the presence of community members, actual control stayed with administrators and elite board members (i.e., business executives and professionals typical of those who had served on earlier iterations of the boards). Board discussions tended to center on technical issues of care and administration, discussions to which community members had little to contribute. Substantive community involvement was further reduced by administrators who used control strategies, such as bringing issues to boards at a later stage in the decision-making process and holding informal discussions outside the boardroom with select elite members.

In a more contemporary analysis of regional boards in Quebec, their role was examined in terms of their ability to effect implementation of policy (Touati, Roberge, Denis, Pineault & Cazale, 2007). Boards working with clinical leaders and administrators were able to effect internal, organizational change and policy implementation, in what the authors termed clinical-administrative governance. The ability of the community board to root the services in local culture and community (i.e., a potential substantive shift as opposed to simply an administrative or structural shift) was not assessed.

An exploration of Nova Scotia's experience led Side and Keefe (2004) to challenge the assumptions of greater community participation that underlies some arguments for regionalization, especially in relation to rural communities. In particular, their research led these authors to challenge the assumptions that (a) community members would be available (i.e., would have the time) to take on the new work and roles required of them under regionalization and community engagement agendas; (b) the community members who do take up the new roles would necessarily be representative of the broader

communities from which they are drawn; and (c) the community work that these community members then go on to accomplish together would be above and beyond any community work that would have occurred without the new roles, thereby producing a net gain in community engagement and action. From focus group and interview data, Side and Keefe suggested that significant community collaboration and mutual support had long been a part of rural life preceding regionalization; it was not necessarily a result of regionalization. They also raised the possibility that collaboration around issues of scarcities and deficits could inadvertently heighten community competition, and in this way could plausibly contribute to losses at the community and population health level.

A handful of evaluations have explored (typically with Likert-scales and mail surveys) the motivations, opinions, and attitudes of central players within Canada's various regionalized health systems. Most of these have been completed on what I will refer to as first-wave regionalization structures (i.e., before the restructuring and amalgamations circa 2000). Lomas, Veenstra, and Woods (1997a, 1997b) weighed in with findings from a survey completed by board members from five Canadian provinces (Alberta, Saskatchewan, Prince Edward Island, British Columbia and Nova Scotia). Among their findings, Lomas et al. noted that, while the structural features of the boards favored their alignment with government expectations and agendas (as opposed to either service providers or communities), the opinions that these board members expressed in the surveys suggested an alliance with local communities. Thus, even though most board members were appointed to their position by the central government (i.e., not elected by local citizens), they reported a strong sense of accountability to local citizens.

Another survey examined the opinions and attitudes of three groups of central actors within regionalized models (i.e., board members, health region Chief Executive Officers, and senior level Ministry of Health staff) in all regionalized Canadian provinces and the Northwest Territories, just as many were on the cusp of introducing second-wave regionalization amalgamations and restructuring (Kouri et al., 2002). All of the respondents supported regionalization, but clear tensions existed among the three groups in terms of role clarity, accountabilities, authorities, and assessments as to who was exerting influence in board decision-making. Many of these findings mirrored earlier findings of a survey with first-wave Saskatchewan boards (Lewis et al., 2001). In a latter re-evaluation of the survey, Chessie (2009) raised questions about the degree to which these boards represent “average” Canadians (noting the privileged status of many members, in terms of age, education, and income, and their incomparability with the general Canadian population). Based on their Likert-scale responses to items assessing ties and commitments to community, this study raised questions about whether these boards would be able to engage and empower communities.

Interviews with senior-staff employed within health regions and within the provincial health ministry in Newfoundland and Labrador reported similar concerns to Kouri et al. (2002), noting a lack of clarity in authority and lines of accountability between the regions and the Ministry (Neville, Barrowman, Fitzgerald & Tomblin, 2005). This latter evaluation did not interview board members, only staff members in the health regions and health ministry.

While board members in British Columbia reported competency in their role and the ability to work well with stakeholders, they also indicated feeling challenged in

effectively representing their broader communities (Frankish, Kwan, Ratner, Wharf Higgins & Larsen, 2002a, 2002b). Board members reported undue influence over their decision-making from government and local administrators, inconsistent direction from the government, and a lack of understanding among regional residents and stakeholders about the role of the board. These findings echoed results from an earlier survey with the British Columbia boards wherein respondents reported some influence over local service delivery decisions, but little influence over central government decisions or priorities (Frankish, Kwan, Ratner & Wharf Higgins, 1999).

A recent external review of regionalization in Manitoba (Gray, Delaquis & Closson, 2008) used consultation, questionnaires, written submission and performance indicators to evaluate progress to date. The authors argued that regionalization in Manitoba produced many benefits including improved service delivery. That said, their findings also noted issues with accountability and authority, echoing earlier provincial findings (e.g., Kouri et al., 2002; Lewis et al., 2001; Neville et al., 2005), leading these authors to recommend a more complete devolution from the Manitoba Ministry of Health to the RHAs and better specification of the roles of RHAs. They also noted inconsistency in use and efficacy of community engagements, and recommended that this problem be addressed to realize the full potentials of regionalization. However, while citing community development, public ownership, and community participation and involvement as important goals of regionalization, the authors of this report then proceeded to locate these activities within the Community Health Advisory Committees (special committees established to provide input to RHAs) and not within the RHAs themselves, even though the RHAs are boards comprised of community members. In this

model, the Advisory Committees represented an additional but somewhat marginalized structure, one-step removed from the RHA—a, theoretically at least, key decision-maker in Manitoba's health system. This side-step (or retreat) parallels that of the 2001 introduction of CANs in Saskatchewan, which were established to serve as an explicit connection between communities and boards when Saskatchewan boards were reduced in number from 32 to 12, and when elections were eliminated so that board members then came to serve through government appointment.

### **2.2.3 Summary**

To summarize, a great deal of the literature that exists on health system regionalization in Canada tends to be centered on questions of system efficiency and effectiveness, questions as to what form and structure works (e.g., the number and size of RHAs, the roles and responsibilities that are part of their duties), or descriptive differences among the models. Rare are studies that attend to its deliberation and democratic potentials, or its plausible community empowerment and population health gains. A subset of the literature focused on describing opinions and attitudes of actors, but these views were obtained via surveys with pre-structured responses. This research style situated survey respondents within the researchers' frameworks, as opposed to open-ended interviews, wherein the vocabularies, concepts, meanings, interpretations, and discourses most relevant to the central actors themselves could more easily emerge.

These evaluations of Canadian experiences with regionalization lead to questions of whether and to what extent community members can be inserted into these new governance models in order to shift traditional decision-making processes, governance structures, and power balances. This literature also suggests that it will take more than

sheer presence and representation of communities and publics to affect decision-making while other players (e.g., health ministry staff, professionals, and elites) continue to exert significant influence in board decision-making. The presence of communities and publics may be necessary for this shift but it appears that it is not sufficient.

While conducting this review, I also noted that the scholarly literature has made little use of social theory to explore research findings and consider the ramifications of the policy changes. While Putnam's notion of social capital was referenced (Lewis 1997; Lomas, 1996; Veenstra, 2002; Veenstra & Lomas, 1999), explicit theoretical links were rare. Frequent reference was made by a number of researchers to the public participation themes of regionalization and its potential to shift power balances between providers and administrators and governments (e.g., Adams, 2001; Church & Barker, 1998; Church & Noseworthy, 1999; Contandriopoulos, 2004; Davidson, 2004; Denis et al., 2004; Eakin, 1984a, 1984b; Frankish et al., 2002b; Lomas, 1997a, 1999; Lomas et al., 1997; Rasmussen, 2001; Trottier, Champagne, Contandriopoulos & Denis, 1999). Early on, however, Alford (1975) identified a triad in health system decision-making which included the (a) traditionally dominant (physicians), (b) traditionally challenging (administrative and government rationers) and (c) traditionally repressed (the community). Alford's own work and more recent empirical data suggests that technical and political authorities tend to align interests at the expense of community and public voice (Alford, 1975; Eakin 1984a, 1984b; Frankish et al., 2002b; Kouri et al., 2002; Trottier et al., 1999). Other literature has encouraged advocates of regionalization to consider whether better means exist with which to insert public values into health system planning and governance, warning that meaningful public engagement, while



theoretically possible, takes time, effort, and resources (e.g., Church et al., 2002; Flood & Archibald, 2005; Frankish et al., 2002a, 2002b; Godbout, 1981; O’Neill, 1992).

## **2.3 The Public Participation Literature**

### **2.3.1 Introduction**

In addition to the literature on Canadian health system regionalization, a second body of literature reviewed for this study was that which examined community and public participation within health sector decision-making in general (i.e., not necessarily under the auspices of a regionalized health system with local governance boards). Articles here tended to fall into one of two types: conceptual considerations of public participation and engagement, and empirical case studies of fora attempting to accomplish community and public participation and engagement.

### **2.3.2 Conceptual Literature**

The first category of literature—based in literature reviews and theoretical frameworks—attends to the conceptual issues of public participation. Writers here encouraged careful consideration as to the “who, what, where, when and why” of public engagement (Abelson et al., 2003; Abelson & Eyles, 2004; Abelson & Gauvin, 2004, 2006; Baggott, 2005; Callaghan & Wistow, 2006; Church et al., 2002; Davies, Wetherell & Barnett, 2006; Dickinson, 2004; Germann & Wilson, 2004; Jewkes & Murcott, 1998; Lomas, 1997b; Macfarlane, 1996; Maloff, Bilan & Thurston, 2000; Martin, 2007; Morgan, 2001; Scutchfield, Ireson & Hall, 2004; Taylor, Wilkinson & Cheers, 2006; Tomblin, 2004; Tritter & McCallum, 2006; W.H.O., 2006 ). These writers urged advocates and planners to consider:

1. the different perspectives publics can bring to the table (Are they expected to represent individuals or collectives, themselves or their communities? Are they to be contemplated as publics, citizens, taxpayers, consumers, patients, etc.?)
2. the intended results of participation (Are participants there to deliberate and guide, to make binding decisions, to advise and provide input to managers and administrators who then make decisions, or are they to listen to reports and receive information concerning decisions and projects underway? Is their participation active and empowering or passive, pragmatic, and utilitarian? Do their intentions match methods?), and
3. the barriers to and resources needed for participation (Do publics want to be there? Why? In what capacity? Are there adequate resources to facilitate the dissemination and sharing of information, consultation exercises, deliberation processes, or decision-making agendas?).

In addition to the above literature and conceptual reviews urging careful consideration and planning, theoretical frameworks have been offered that help organize these issues. For example, Charles and DeMaio (1993) provided a framework to guide considerations of public participation that located the above issues along three axes: the levels at which publics were to participate (consulting, partnering, leading, and deciding); the role they were to assume (service user or general public); and the domain of issue under consideration (micro, meso, macro, or treatment, service, policy). A seminal framework from Arnstein (1969) on citizen engagement (but not specific to health), provided an expanded range of options for the level of participation ranging from manipulating publics, to informing, consulting and placating publics, to partnering with,

delegating to and being controlled by publics. More recently, Tritter and McCallum (2006) proposed modifications to Arnstein's framework to make it, they argue, more nuanced and applicable to the health field. Two of their modifications of interest here included (a) expansion of the role categories to allow for multiple and dynamic roles among users (patients and clients), citizens (voters, taxpayers) and consumers, and (b) expansion of the level of participation category to allow for public involvement in areas such as framing problems and not just service delivery decisions.

This notion of different seats for publics (i.e., patients, citizens, etc.) was also detailed by Davies et al. (2006) and Clarke, Newman, Smith, Vidler, and Westmarland (2007). Participating as citizens, engagement is active and located in a person's legal rights and obligations in a western democratic state to guide states and hold them accountable for decisions made for and on their behalf (Davies et al., 2006). As citizens, participation is public, is about collective interests, and is rooted in relationships with the state (Clarke et al., 2007). In comparison to this view of the public as citizen, other conceptualizations of the public are framed within discourses of consumers and customers, where people decide what goods and services we will choose from amongst the choices available, and simultaneously, where publics shape what future services are available, by sharing their needs and wants (Davies et al., 2006). As consumers, participation is private, is about personal interests, and is rooted in relationships with the economy and market (Clarke et al., 2007).<sup>14</sup> Davies, et al. (2006) further theorize the concepts of participating publics to include "hyphenated citizens" (2006, p. 2) such as

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<sup>14</sup> The notion of consumption and commodification of a publicly funded good such as health care take on contentious references within the boundaries of Canadian health systems, a thorough discussion of which falls outside the realms of this literature review. Interested readers are encouraged to consider, for example Feldberg and Vipond (1999), Bunton et al. (1995) and Grace (1991).

“citizen-residents” who help shape decisions about the location of services, and “citizen-service user,” who help shape decisions on the provision of services.

Collins and Evans (2002) also offered a highly contested (see for example Jasonoff, 2003; Rip, 2003; Wynne, 2003) normative model for public participation in policy decision-making exercises in general, not necessarily specific to health care and health system policy. Rooted in science studies and wrestling over concerns between technocratic elites and political legitimacy with extensions of public participation, they argue a necessary and fruitful expert-public boundary has been dissolved. They posed a new model that inserts some publics into some policy deliberations by tying public participation to experiential-based expertise claims (e.g., the expertise of an experienced farmer, or in the current context, that of an experienced patient). With this expertise, some publics are then legitimate contributors to policy deliberations of technical issues.

### **2.3.3 Empirical Evaluations of Public Participation**

While the first category of literature attends to the conceptual issues of participation, the second category includes a rapidly growing body of case studies and empirical evaluations wherein evaluators and researchers are working out the procedural specifics, identifying the complexities and challenges of engagement, and offering recommendations to guide future considerations and planning (e.g., Abelson et al., 1995, 2003, 2004, 2007; Contandriopoulos, 2004; Crowley, Green, Freake & Drinkwater, 2002; Davies et al., 2006; Dolan, Cookson & Ferguson, 1999; Kashefi & Mort, 2004; Maxwell, Rosell & Forest, 2003; Montpetit, Scala & Fortier, 2004; Pickard, 1998; Pivik, 2002; Thurston, et al., 2005; Wallerstein, 2006; Wharf Higgins, 1999). These studies have concluded that meaningful participation within health system decision-making cycles

takes conscious planning and effort, and many evaluators and researchers have offered practical advice to readers planning specific public participation fora.

The findings from these studies have suggested that it is easiest for publics to represent themselves as clients or consumers (e.g., Lomas, 1997b), but that with support, they can represent themselves as citizens (e.g., Maxwell et al., 2003; Singer, 1995). Some authors have also argued that the findings show publics to prefer providing input and advice as opposed to actually making decisions (e.g., Abelson et al., 1995; Lomas, 1997b; Wiseman et al., 2003). There appears to be a growing consensus among public participation researchers and advocates that good participation starts early in a decision-making process and attends to two-way information sharing, communication and deliberation (e.g., Abelson et al., 2003, 2004; 2007; Dolan et al., 1999; Kashefi & Mort, 2004). Calls have been made by these researchers for alternative means of including traditionally underrepresented publics (e.g., Crowley et al., 2002; Jewkes & Murcott, 1998; Wharf Higgins, 1999) and that new means of institutionalizing participation in public policy processes be considered (e.g., Turnbull & Aucoin, 2006). Moreover, these authors urge readers to pause and critically consider the ideas and preconceptions that lead to such broad and widespread support for public participation initiatives and consider whether better means might exist with which to change power relations (e.g., Contandriopoulos, 2004).

In the international literature, social theory has been applied to initiatives based mostly within Britain's National Health Service (NHS). For example, Milewa has authored a series of these articles (Milewa, 1997a, 1997b, 2004; Milewa, Dowswell & Harrison, 2002; Milewa, Valentine & Calnan, 1998, 1999) and has concluded that,

despite the increasing rhetoric of public participation, and despite the potential for public engagement to redefine the relationships among the public, providers, and managers and administrators, public involvement has been largely driven by managers. In this way, public engagement has come to serve as an administrative tool complementing health system planning and management, but not public participation and citizenship (Milewa, 1997a, 1997b, 2004; Milewa et al., 2002, 1998, 1999).

Other evaluations of public participation within the NHS echoed these findings and have reported an increase in public consultation but not active public participation. Harrison and Mort (1998) label participation and engagement “technologies of legitimation,” a provocative term to denote the use of public participation merely as a means of deflecting criticisms of democracy. Such restricted use of participation (i.e., potentially manipulative, passive consultation as opposed to more authentic, active participation) has been reported in other NHS reviews (North & Werko, 2002; Pickard & Smith, 2001; Rowe & Shepherd, 2002). One major barrier to active participation and citizenship engagement may be the resistance of traditional stakeholders. Calling on Pierre Bourdieu’s notions of habitus, capital and field, and Steven Lukes’ three dimensions of power (force, dominating values and beliefs, systemic bias), Callaghan and Wistow (2006) found that these traditionally powerful actors (i.e., health care providers and health system managers) viewed public involvement as a threat to rational decision-making. These professionals favored “objective” data (i.e., numerical information methodically drawn from a representative sample) and expert knowledge, not public views. Callaghan and Wistow found that the professionals maintained their power within

public participation forums by using meeting agendas to set the terms of the debate and limit the potential for these reforms to impact beyond these constructed boundaries.

Martin (2007) approached public participation within a Foucauldian governmentality framework. Using discourse analysis of NHS documents detailing public participation initiatives, he showed public participation was positioned neither solely within a technocratic logic (reducing publics to consumers and patients with knowledge and expertise to offer planners), nor a democratic logic (raising participants to representative citizens and empowered decision-makers), but as both. Martin encouraged stepping outside the technocratic/democratic dichotomy by interpreting it as a development in contemporary techniques of governing. In this way, Martin argued, public participation can be understood as a means by which governments increase their knowledge of and insight into the people whom they govern and whose conduct they regulate. Public participants then become mediators of the interface between state and society; they aid governments in their need to know citizens and develop effective means of governing and servicing these “free” individuals.

#### **2.3.4 Summary**

Much attention has been given to the procedural complexities and challenges of public participation, and there is a plethora of case studies examining the strengths and weaknesses of various approaches. Some evaluators position participation in terms of health system planning and efficiencies, while others appear to imbue it with empowerment and democratic potentials.

In general, the literature views public participation in health care decision-making as a challenging yet potentially promising route to a democratization of the system and a

general strengthening of our democratic culture (e.g., Abelson et al., 2003; Abelson & Eyles, 2004; Abelson & Gauvin, 2004; Dickinson, 2004; Maxwell et al., 2003; Montpetit et al., 2004; Tomblin, 2004; Turnbull & Aucoin, 2006). But there have been challenges to this view. For example, Contandriopoulos (2004) questions the underlying assumptions supporting public participation paradigms (i.e., that participation is intrinsically good and desirable, that participation necessarily leads to democratization, and that it is an effective way of mitigating power imbalances). In general, however, the literature appeared supportive of public involvement, and researchers have worked to fine-tune the processes and deepen conceptualizations of participation and engagement, rather than skeptically questioning and critically considering public participation as a concept to interrogate.

There has been some critical attention directed at public participation initiatives, largely from researchers studying health reform within the NHS. Researchers question the new mentalities that are developed with public participation logics (e.g., Hughes & Griffiths, 1999; Joyce, 2001; Light, 2001; Martin, 2008; Prince, Kearns & Craig, 2006), raising the possibility that these new initiatives effectively function as technocratic, managerial tools (e.g., Callaghan & Wistow, 2006; Milewa, 1997a, 1997b; 2004; Milewa et al., 2002; Milewa et al., 1998, 1999; North & Werko, 2002; Pickard & Smith, 2001; Rowe & Shepherd, 2002). Others have considered these activities as manipulations (e.g., Harrison & Mort, 1998), whose enactment plays “smoke and mirror” games, if you will, with the concepts of legitimacy and accountability. Throughout this literature, tensions exist between democratic and technocratic logics. Is public participation rooted in citizenship status and thus about strengthening democracy and public accountability, or is public participation a technocratic tool designed to help professionals and experts better



plan and tailor services to user needs and specifications? When are citizen knowledge and values sought in health system planning and decision-making, and when is the knowledge of professionals and experts sought?

## **2.4 Guiding Logics<sup>15</sup>**

Logical framings are important to consider because they come to be ways of seeing the world, ways that concomitantly privilege certain vocabularies, ideas, truths and subjectivities, while marginalizing and blurring others (Brodie, 2008; Clarke, 2007; Dean, 1999; Foucault, 1991; Miller & Rose, 1990; Rose, 1999; Williams, 1977).

I have organized the logics into four groups. I am not suggesting that this grouping represents an exhaustive list, but they do represent four of the stronger themes that emerged in the literature. The four logics are presented here as “ideal types” (Weber, 1949), conceptual categories that call on logical differences and extremes to facilitate comparison and analysis, and against which actual practices then adhere or deviate. Thus, while presented here as exclusive groups, these categories are an over-simplification since in reality the arguments and logics are not necessarily so extreme or mutually exclusive. Indeed many authors and commentators have argued from multiple, blended, “hyphenated” (Davies et al., 2006, p. 2), and even contradictory positions.

The four logics were (a) empowerment and population health logics, advocating community participation as routes to population health gains; (b) public sphere and democratic logics, advocating citizen deliberation and participation as routes to healthy public spheres and democracy; (c) internal, health system-directed planning and efficiency logics, advocating public engagement as a route to better health system

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<sup>15</sup> An earlier version of this next section was presented at the Annual Meeting of the Canadian Sociological Association (Chessie, 2007). It has been re-worked and extended here.

planning and thus healthier health systems; and (d) modes of governing logics that can be extended to advocate skeptical participation (or even non-involvement). The focus on governing logics examines the way in which public participation agendas are constructed, and/or the ways in which these initiatives affect the interface between publics and states, and extend and deepen a government's ability to regulate the conduct of individuals and groups, as well as facilitating effective governance by the governors.

#### **2.4.1 Population Health Logics: Participation is Good for Health**

A population health framework has specific implications for public policy that are not politically or ideologically neutral. The evidence strongly suggests that we would be a much healthier population if we had the foresight, inclination and ability as a society to nurture positive and supporting living conditions, which would involve both the reduction of levels of material inequality within our social order, and a relative retreat from the cultural ethos of individualism (Hayes & Dunn, 1998, p. 6).

Some scholarly statements on regionalization and public participation initiatives hone in on their potential to provide avenues for people and communities to come together and, through active participation, exercise control over decisions affecting their daily lives. This action, theoretically at least, creates empowerment, which in turn, offers the potential for population health gains (e.g., Canadian Public Health Association, 1996; Germann & Wilson, 2004; Hayes & Dunn, 1998; Jewkes & Murcott, 1998; Labonte, 2003; Labonte & Edwards, 1995; Pivik, 2002; Polanyi & Andres, 2003; Robertson & Minkler, 1994; Scutchfield et al., 2004; W.H.O., 1987, 2006). Simply put, empowered people and communities are healthier people and communities.

When calling on this logic, writers often cite the social determinants of health, reminding readers that factors outside of the health care system contribute to health, including individual behaviours and biology, both influenced by social and physical environments (e.g., Evans & Stoddart, 1990). Within population health logics, public

participation in health system planning and governance offers the potential to better align the system with local health needs and thereby enhance system effectiveness. Embracing population health logics would plausibly increase health system accountability to the communities served and thereby enhance system efficiency. But empowering individuals and communities could also contribute to an improvement in population health gains since these publics are drawing on their local knowledge of health issues and making an investment in their communities.

#### **2.4.2 Democratic Logics: Participation is Good for Democracy**

Most experts in the health sector pose the problem of public participation in a framework that is rather narrow .... But in reality, just as health goes far beyond the health care system, public participation is much broader in scope than the management of a hospital or regional health authority. It expresses citizenship values (Forest, 2004, p. 11).

By weaving in concepts of civil society and active public spheres, writers imbue a public policy with democratic potentials (e.g., Church & Noseworthy, 1999; Cohen, 2005; Dickinson, 2004; Forest, 2004; Jensen & Suchman, 2004; Lewis, 1997; MacKinnon, 2006; Maxwell et al., 2003; Murphy, 2005; Neale, 2004). It is not just that communities and populations can achieve health gains via participation (although this outcome can occur), but that the health of public spheres and thus our very systems of western democracy are strengthened. A common theoretical framework often referenced when arguing within this logic is the Habermasian theory of societal rationalization (Habermas, 1984, 1987a) and related notions of deliberative democracy (e.g., Cohen & Arato, 1992; Dryzek, 2000; Ferree et al., 2002). I will turn to Habermas in more detail in the next section of this chapter, but for now, suffice it so say that Habermas (1984, 1987a) argues that when citizens come together in public spaces and, with reason and rationality, debate and deliberate common issues, a shared understanding can be achieved

as to the values, principles, and needs that these publics feel should guide public institutions (such as, in this case, a publicly-funded and state-administered health system). In this way, publics can engage in “communicative rationality,” defending and liberating public spheres from strategic and instrumental rationality. This perspective on the public sphere and democracy encourages the creation of new public spaces of communication and deliberation (such as those created through RHAs and public participation agendas). Indeed, commentators have used a Habermasian perspective to argue in favour of health system public engagement opportunities (e.g., Dickinson, 2004; Jensen & Suchman, 2004; Murphy, 2005; Neale, 2004; VanderPlaat, 1998).

With this logic or set of guiding arguments, investing communities and regional health authorities with such deliberative potential provides an opportunity not only for the democratization of the health system but, more importantly, for the larger society as well. Citizen participation under this framework is about more than participation in the RHA, the health system, the health needs of the community, or even health; instead, citizen participation is about providing opportunities to identify (through discussion) and form (through deliberation) common values, principles, and needs, and in this way, strengthen civil societies and democracy.

#### **2.4.3 Technocratic Logics: Participation is Good for the Health System**

Redefining much of public policy in health terms is in a sense revolutionary. Given the obstacles to effective, widely supported, and lasting health-oriented policy development, there is a great deal of public intellectual groundwork to lay (Lewis, Saulnier & Renaud, 2000, p. 515).

Another perspective within which writers have positioned public engagement and the introduction of local health boards reflects technocratic or instrumental logics, guided by considerations of the most rational, efficient and effective means to a given end

(which could well be democratic, as in the broader case of these opening speakers), what Weber referred to as a practical rationality that guided *zweckrational* action (Kalberg, 1980). Within this set of arguments, public participation and regionalization can be viewed as routes to inform both publics and the health system (e.g., Lewis et al., 2000; Saskatchewan Health, 1996; Touati, 2007). Public participation initiatives are linked to questions of how to efficiently and effectively run and organize health systems, as well as planning questions that benefit from connections with engaged users and publics. Individuals, patients, publics, and communities participate to inform planners and decision-makers of their needs, wants, and perhaps the limits of their support. Health system planners and decision-makers use these fora to, inter alia, educate publics and shape their opinion, building support for their expert proposed solutions and reforms. Within this logic, participation exercises approach engagement not as opportunities to have empowered communities controlling local decisions (as per a population health logic). Nor does public participation provide opportunities to hear what publics value and engage them in deliberations to generate rational opinion and common will to then guide the political-administrative system (as per a democratic logic). Instead, public participation exercises are seen primarily as avenues within which planners and decision-makers present ideas and supporting evidence, hear the limits of public support for these ideas and, where possible, arrange support for these ideas. Public participation is primarily about better planning and executing services and systems.

Table 2 summarizes contrasting positions among these three logics, highlighting distinctions among them. Recall that they are ideal types, and thus this table emphasizes maximally contrasting features amongst the three. It is important to note that in actual

Table 2: Comparative Summary of Three Competing Logics

Population Health Logics	Democratic Logics	Technocratic Logics
<ul style="list-style-type: none"> <li>• Communitarianism</li> <li>• Direct Democracy</li> </ul>	<ul style="list-style-type: none"> <li>• Liberalism</li> <li>• Deliberative Democracy</li> </ul>	<ul style="list-style-type: none"> <li>• Liberalism</li> <li>• Elitism</li> </ul>
<ul style="list-style-type: none"> <li>• Active participation of communities, families, disempowered groups, collectives</li> </ul>	<ul style="list-style-type: none"> <li>• Active participation of citizens, tax payers, residents, collectives and individuals</li> </ul>	<ul style="list-style-type: none"> <li>• Passive participation of patients, users, clients, consumers, and individuals</li> </ul>
<ul style="list-style-type: none"> <li>• Lay experts</li> <li>• Knowledgeable communities</li> <li>• Community leaders</li> <li>• Marginalized voices</li> </ul>	<ul style="list-style-type: none"> <li>• Representative lay</li> <li>• Representative citizens</li> </ul>	<ul style="list-style-type: none"> <li>• Experts (patients, CEOs, etc.)</li> </ul>
<ul style="list-style-type: none"> <li>• Community-based decision-making</li> <li>• Empowerment</li> <li>• Engagement</li> <li>• Doing</li> <li>• Sharing</li> <li>• Becoming healthier</li> <li>• Macro, meso and micro-level decisions and deliberations</li> </ul>	<ul style="list-style-type: none"> <li>• Legitimacy</li> <li>• Accountability to community</li> <li>• Oversee</li> <li>• Open and visible</li> <li>• Guiding pulse for legitimacy and accountability</li> <li>• Macro-level decisions</li> </ul>	<ul style="list-style-type: none"> <li>• Plan</li> <li>• Fine-tune</li> <li>• Input to planning</li> <li>• Micro to meso-level decisions</li> </ul>
<ul style="list-style-type: none"> <li>• Decision makers are communities</li> </ul>	<ul style="list-style-type: none"> <li>• Decision makers are the demos</li> </ul>	<ul style="list-style-type: none"> <li>• Decision makers are the technos</li> </ul>
<ul style="list-style-type: none"> <li>• Questions of “ought” and “is/can”</li> </ul>	<ul style="list-style-type: none"> <li>• What “ought” we do?</li> <li>• knowledge rooted in citizenship and value systems</li> <li>• Power with demos</li> </ul>	<ul style="list-style-type: none"> <li>• What “is” possible?</li> <li>• knowledge rooted in technes and awareness of system capabilities</li> <li>• Power with technos</li> </ul>
<ul style="list-style-type: none"> <li>• Lifeworld actions affect lifeworld and system</li> </ul>	<ul style="list-style-type: none"> <li>• Lifeworld actions affect system</li> </ul>	<ul style="list-style-type: none"> <li>• System actions affect system</li> </ul>
<ul style="list-style-type: none"> <li>• Goal = healthy people</li> <li>• Lifeworlds control lifeworlds and systems</li> </ul>	<ul style="list-style-type: none"> <li>• Goal = healthy democracy</li> <li>• It is a “right” and “responsibility” as citizen to deliberate</li> <li>• Public values shape technos and system decisions</li> <li>• Rooted in citizen and her democratic relationship with “state”</li> <li>• Lifeworlds control (pulsing) systems</li> </ul>	<ul style="list-style-type: none"> <li>• Goal = healthy health system</li> <li>• It is a right as consumers, clients, patients to have a say</li> <li>• System control systems</li> </ul>

practice, writers more often call on blended and hybridized logics. It is also important to note that, in and of themselves, these logics do not contain value judgments and are not inherently “good” or “bad.” Instrumental reasoning and technocratic logics may carry a negative connotation for some readers, but it is important to remember that these ideas can (and often are) used for democratic exercises (e.g., to support the fair distribution of health care services and health). Similarly, while empowerment ideologies and population health discourses may appear to carry more immediately positive connotations, they can in effect also quite readily carry very oppressive and limiting ideas (e.g., the image of an all knowing and benevolent community, that emphasizes similarity amongst members, thus marginalizing difference). Conversely, a citizen board member, operating within a narrow, representative, interest-based role, could in practice be more technocratic than a board member operating with a broader, public interest, representative function. Differences aside, all three logics are similar in that embedded within their assumptions is an understanding of the best way to govern the health system (i.e., by the people, with the people, for the people). I turn now to a fourth, more unique logic, one offered through a governing-mentality lens and that interrogates this very notion of a best way.

#### **2.4.4 Governing-Mentality Perspective: Participation is Good for Governing**

One could argue that particular forms of health-needs assessment and the “new public health” concept are all aspects of a problematisation within a discursive space that makes health care amenable to political action (Joyce, 2001, p. 598).

Writers within this logic, view health reforms (whether via regionalization, devolution, decentralization, public participation, community engagement, or any other strategy) not as means to an end of better health (as per a population health logic), better democracy (as per a public sphere or deliberative democratic logic), or better health

systems (as per a technocratic logic), but instead as strategies of governing and regulating the conduct of populations, or better governance (e.g., Hughes & Griffiths, 1999; Joyce, 2001; Light, 2001; Martin, 2008; Prince et al., 2006). Calling on the work of social theorist Michel Foucault (1991), as extended by Rose and Miller (1992), health reform and new ways of organizing the governance of the system (e.g., with regional boards) and gathering knowledge (e.g., through public participation agendas) are innovations in techniques of governing populations. I will extend this Foucauldian lens and detail this logic in a following section in this chapter, but suffice it to say that changes in the current structures of health system governance and strategies of health system reform from a Foucauldian perspective are viewed as new mentalities of governing. These new mentalities produce new types of expertise and embed practices within new discourses, new knowledge claims, new questions, and new subjectivities. In the particular case of reforming models of health system governance, there is a tendency to find ways to “govern at a distance,” and to produce active, engaged, self-governors who take responsibility for their health and that of their community, effectively individualizing risk and responsibility while occluding consideration of structural determinants of health (Hippe, 2010; Shim, 2000).

## **2.5 Summary**

I have thus far summarized two bodies of scholarly literature reviewed in preparation to undertake the current study. These literatures explicitly informed my consideration of the issues of regionalization and public participation in health system decision-making by highlighting what was known in these areas, how these areas had been investigated and considered, the gaps in knowledge, the methods and approaches commonly applied to studies in the area, as well as the logics and arguments in this



literature. This review also identified some of the conceptualizations and issues that have emerged in the field (e.g., the notion of competing roles for publics, as patients or consumers or citizens), as well as some social theoretical lenses applied to the field.

As seen from these literatures, there is still much to know about this innovation of “regionalization.” Much of the recorded discourse and debates are rooted in the opinions and experiences of academics, public policy advisors, and other discourse elites. Less attention has been paid to the policy architects and carpenters -- the civil servants, policy advisors and writers, health region executives and community board members, and advisory network members who frame, interpret, and practise regionalization and public participation within Saskatchewan’s model of health system governance. Much of the research into regionalization and public participation has been quantitative and deductive, rooted first in the researchers’ voices and questions. For these reasons, I felt it was important to pursue a qualitative exploration of regionalization and public participation, rooted in voices of the actors who have interpreted these policies and constructed its day-to-day practices. As stated, in between official, scripted announcements (that capture intentions, rhetoric, and ideology) and the practices that eventually result from them, lay the interpretations and understandings of everyday actors. *Their* interpretations and guiding logics are influential and worthy of study.

## **2.6 Theoretical and Conceptual Frameworks**

Before proceeding beyond the literature to the specifics of the current research, I want to consider two socio-theoretical frameworks that offer insights into forms of community governance structures and public participation initiatives. The tensions in the literature reviewed herein, between, on the one hand, a cautious optimism for increased

public participation in health system governance and decision-making and, on the other hand, concerns over the extension of governance techniques, are ably captured by the work of Jürgen Habermas and Michel Foucault respectively. Within the social theory of Habermas, one approaches public participation as a potential democratizing force. In contrast, Foucault argues that shifts in governance models represent innovations in governing and new forms of regulating the conduct of populations. I argue, however, that neither theory alone is sufficient; rather, both frameworks help move forward my exploration of regionalization and public participation. Let us examine each of these socio-theoretical frameworks in more detail.

### **2.6.1 Habermas and Normative Potentials of Regionalization and Participation**

As Abelson et al. (2003, p. 240) suggest, the health system has been gripped by the deliberative paradigm, and is a means to engage Canadians in setting the values and priorities to guide our publicly funded health care systems. Calls for greater community involvement in decision-making and governance are not limited to the Canadian health care scene, however, and have occurred within other countries and public sectors (e.g., Boon & Meilby, 2000; Elstad, 1990; Jensen & Suchman, 2004; Neale, 2004; North & Werkö, 2002; Parkins, 2002; Rui, 2004). Rui (2004, p. 131) linked this attention to engagement to three forces: (a) an administrative movement to modernize the functioning of the state, (b) a political movement to legitimate the state, and (c) a public movement to democratize the state. Habermas's theory of communicative action (Habermas, 1984, 1987a) and related notions of deliberative democracy (e.g., Dahlberg, 2005; Dryzek, 2000; Fishkin, 1991; Habermas, 1996a, 1996b) is one theoretical framework that can anchor pro-engagement arguments.

Distinguishing himself from theorists who approached modernization as a one-dimensional force, ushering in increasing waves of rationality and bureaucratization, to inevitably end in the Weberian “iron cage,” Habermas (1984, 1987a) theorizes a more optimistic resolution. He argues that what we have witnessed to date in the Western world is the differentiation of society into system (comprised of a political-administrative state and the economy) and lifeworlds (with both public and private spheres). In order to realize the potentials of modernity, both system and lifeworld need to be rationalized, but with distinct processes. Formal rationality (i.e., instrumental and strategic rationality aimed at applying the best means to achieve a given end, and the rationality that was the focus of Weber and his “iron cage”) is necessary to modernize the system, but communicative rationality (i.e., an inter-subjective rationality aimed at establishing shared understandings), is required to modernize lifeworlds. As Habermas argues, it is only through the simultaneous advancement of *both* of these rationalities in their specific domains (i.e., functional rationality in the political-administrative state and economy and communicative rationality in lifeworlds) that the potentials of modernity can be realized (1984, 1987a).

In detailing the nature of the relationships between individuals and the system within this dual-model (i.e., system and lifeworld), Habermas (1987a, p. 320) positioned individuals with four roles relative to the state and the economy. In the public sphere, relative to the state (which is steered by power), we are citizens (giving legitimacy and loyalty to the administrative system in return for political decisions), and we are clients (giving taxes to the administrative system in return for welfare state accomplishments). In the private sphere, relative to the economic system (steered by money), we are workers

(giving labour to the economic sub-system in return for income) and consumers (giving demands to the economic system in return for goods).

The above presentation is an ideal-type, and Habermas argues that the reality witnessed in contemporary western worlds is an overextension of system rationalities and “colonization of the lifeworld.” In Habermas’s view, lifeworlds are to be spaces of communicative rationality, steered by inter-subjective communication; instead, however, they are being increasingly filled with functional rationality and interactions steered by power (the steering medium of the state) and money (the steering medium of the economy). The result is an anemic lifeworld and a hyper-developed system wherein the administrative state redefines practical questions as technical matters for experts, where demands for substantive justice are met with legalistic solutions, and where the decisions and actions of the state become ever distanced from an increasingly muted public will.

Habermas continues that, although one-sided rationalization is the path followed to date, there is an alternative wherein communicatively rational lifeworlds support vibrant public spheres (that are inclusive, public, and status-free) in which deliberated public opinions can form. These deliberated opinions would then bundle to become a political will that in turn shapes the formally rational decisions and actions of the political-administrative state. Habermas sees this normative model as a fundamental strategy not just for defending lifeworlds against colonization but for developing authentic democracy (i.e., a deliberative democracy) wherein deliberated political wills (as distinct from those formed additively via opinion polls) would guide state action. In short, communicative rationality would establish the ends, and formal rationality the means (Habermas, 1996a, 1996b).

When applying Habermasian social theory and notions of deliberative democracy to governance models within Canadian health care, decisions to regionalize provincial systems and invest community members with authority to govern local services and participate in decision-making have been argued as significant opportunities for health policy, but also the public sphere and democratic society (e.g., Dickinson, 2004; Forest, 2004; MacKinnon, 2006). Community boards have the potential to engage in communicative rationality, consider issues of public policy and health system reform, and form a deliberated opinion and political will to then steer the administration and decision-making apparatus of the state (as represented in this specific case by the provincial Ministry of Health). It is equally plausible that CANs, the community links introduced in second-wave regionalization in Saskatchewan to facilitate RHA connections to and engagement with their broader communities, have a parallel influence on RHAs. Furthermore, the administrative state (again, as represented in this specific case by the Ministry of Health and/or the RHAs) would have, via this deliberative democracy, the potential to write democratically constituted laws and acts, a hallmark of the Habermasian deliberative democracy (Habermas, 1996a, 1996b).

Arato and Cohen (1988) extended Habermas's theory to explicitly locate "civil society" (i.e., the institutions and formal associations within the public sphere of the lifeworlds). In their analysis of social movements, Arato and Cohen argued that the institutions of civil society could "defend" and secure the lifeworld and minimize its colonization. Furthermore, civil society organizations could also penetrate the political-administrative system with lifeworld sensibilities in "offensive" projects, wherein lifeworld norms are linked to the state via "sensors," thereby keeping the state open to

influence from civil society. Situated at the interfaces of lifeworlds and the system, these institutions and organizations of civil society could offer the potential to usher lifeworld influences to the state but, in dialectical fashion, they also offer the potential to facilitate penetration of system logic into lifeworlds (Habermas, 1987a).

Habermas's theory of rationalization and deliberatively-based democracies asks how well the form and function approximate the ideal (i.e., do these sites serve as public, inclusive, and deliberative spaces wherein the deliberations produce a will that then steers the decision-making and actions of the administrative state?). This theory also opens a space from which to consider the paradoxical nature of the interface. The notion of lifeworld colonization opens up the possibility that participation in RHAs and CANs may not only strengthen public spheres and affect (through its creation of guiding values and principles) a central state, but that these sites may extend the penetration of system rationalities into the lifeworlds. This interface and paradox invites critical examination of where and when these manufactured public spheres<sup>16</sup> serve as sites of democratization, aiding the flow of lifeworld norms and values to the administrative state, but also where and when they aid the flow of system rationalities to the lifeworlds.

### **2.6.2 Foucaultian Critiques and Sensitizing Issues**

Foucault disagreed with the notion of a public sphere separate from a central state (Rose & Miller, 1992), and approached "civil society" and "government" not as collections of institutions and actors performing certain functions but as constructions to be interrogated (Dean, 1999, p. 24). Where Habermas, as a quintessential modernist, concerned himself with whether and how democracy is possible, and the role of

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<sup>16</sup> The RHAs, created as they are by the state (as opposed to resulting from organic movements within the public sphere), are equated with the "manufactured civil society" as detailed by Hodgson (2004).

deliberation and democratization in societal rationalization, Foucault, with his post-modern sensibilities, instead encouraged asking how it is that these very constructions came to be and how (and what) they constitute, circumscribe, structure, and regulate (Ashenden, 1999; Dean, 1999). Foucault's methodology encourages researchers to examine what *is*, rather than theorizing the normative and ideal. Instead of spending our analytical time interrogating practices to see how closely they approximate an ideal, Foucault's methodology focuses on the practiced realities that power effects and perpetuates problematic social arrangements. His work questions whether constitutions are practised democratically, and not whether they were written democratically (Foucault, 1972-1977/1994; Flyvbjerg, 1998). Moreover, a Foucaultian lens would lead one to note that Habermas' notion of the ideal presumes (a) that there is agreement about the ideal and (b) that this ideal would work if enacted in practice.

For Foucault, "liberalism" was not an ideology but a rationality, a practice, a way of doing things (Foucault in Dean, 1999, p. 174). With this rationality came technologies, areas of knowledge and expertise, capacities, subjectivities, objectives, and effects (Dean, 1999; Rose & Miller, 1992). Following this approach, Dean (1999) argues that the task is not to theorize an ideal type and ask how we might make practices better approximate this ideal, but to ask from whence this very model emerged? How we came to be operating within it? And, by extension, what were the alternatives? (Dean, 1999, p. 20).

In opposition to state theorists who, Foucault argued, attended too much to institutions (and too little to actual practices) with the purpose of deducing state activities from structures and properties of the state, Foucault urged an inversion. He proposed that these institutions are the result (not the cause) of practices, and that changes in practice

produced changes in institutions (not the opposite). He argued that changes in practice take priority over structural changes (Foucault as cited in Dean, 1999, p. 4). Although political studies and concerns for state legitimation are not useless, Foucault did not see how their factual descriptions support critique, problematizations, innovations, and changed thinking (Foucault as cited in Dean, 1999, p. 7).

Foucault introduced the term “governmentality” to refer to “governmental rationality,” and he was interested in “government” not as a site or collection of institutions and actors, but as an activity aimed at shaping and affecting conduct of ourselves, others, social institutions, communities, or states (Gordon, 1991, p. 2; Dean, 1999, p. 2). A “rationality of government” becomes a way of thinking about practices of government (who can govern, what governing is, what and who is governed), that makes certain forms of governing activities thinkable and practicable (Gordon, 1991, p. 3). Governmentality captures how we think about (i.e., our mentality) governing and exercising authority and the attitudes and practices that result (Dean, 1999). An analysis of government is thus not concerned with who governs whom and from where, but is concerned rather with the forms of knowledge and truth that become central to the practices of governing, the beliefs and opinions behind the practices, the techniques employed, the aspects of being governed, the ends sought, and the consequences (Dean, 1999). Using this approach, we would study how and what RHAs do (not who they are), when they were formed, by what legislations, and so forth.

Analytics of governing mentalities attend to the “how” of governance, and Dean, following the work of Deluze (as cited in Dean, 1999, p. 23), detailed procedures for completing analyses of governing mentalities. In particular, Deluze encouraged



questioning along four axes: visibilities (how we see and perceive), knowledge (how we think, question, and produce truths), techniques and practices (how we employ knowledge, expertise, and techniques to intervene and direct), and identities (how we form subjects, actors, and agents). Analyses of governing mentalities are to avoid universal positions; as Dean (1999, p. 36) writes, the point of analysis is not to identify “good and bad” or “dominating and liberating” and from there identify opportunities for liberation; rather analysts of governing mentalities should practise a type of critique that makes explicit forms of thought, assumptions, and the conditions under which individuals and groups think and act. From here, the ramifications of actions taken by actors can be considered, responsibility for the effects of actions assigned, and possibilities for doing otherwise be identified. Following this approach, RHAs do not become structures simply created through a piece of legislation that writes them into being; RHAs are the products of day-to-day practices in which actors engage, the knowledge and expertise that they develop, and the capacities and subjectivities they prioritize, and it is these processes and practices that should become the analytical and critical focus.

Within a Foucauldian framework, regionalization (and its concomitant attention to community and public participation initiatives) and its rapid uptake into Canadian public policy in general and, in Saskatchewan as a particular case, signals a shift in the logics of governance. This perspective on regionalization, and in particular the involvement of publics and communities in health system governance, leads to the interrogation of these practices with questions such as why now? What specific events and situations culminated in changing the governance model(s)? What do the new models accomplish and how? How do the shifts affect state-society interfaces and what boundaries change?

What do actors within this model do? What are their practices? What comes into focus (and what is blurred) with these practices? What new actors and subjectivities are born? What new alliances form? What capacities and attributes are called upon and favored? What knowledge and expertise is required to support this rationality?

### **2.6.3 A Fusion of Habermasian and Foucaultian Approaches**

Foucault's governmentality lens has been applied to public sector reform (e.g., Cheshire & Lawrence, 2005; Herbert-Cheshire & Higgins, 2004; Ilcan & Basok, 2004; Power, 2005; Spencer, 2007), including health reform and public participation initiatives (e.g., Hughes & Griffiths, 1999; Joyce, 2001; Light, 2001; Martin, 2008; Prince et al., 2006). Following suit, my intention is to use Foucault's ideas of governmentality to interrogate the practices of regionalization and interpretations of public participation (as understood by central actors). Foucault's work offers a lens for remaining sensitive to power and its micro-practices, as well as attending to issues of difference, diversity and identity. Foucault, with his proclivity for considering the margins, has been posited as a suitable anchor for such explorations (Flyvbjerg, 1998).

That said, attending to micro-practices of regionalization and public participation runs the risk of ignoring the power of a centralized state. Other researchers have flagged that a limit to governmentality approaches is its inability to adequately theorize and consider the role of a central state (e.g., Flyvbjerg, 1998; Hughes & Griffiths, 1999; Marinetto, 2003; McCarthy, 1994), arguing that despite the de-centering of power, central states still exist and exert influence, and thus need to be considered. Indeed, Hughes and Griffiths (1999), when applying a governmentality lens to de-centralized health system governance practices in the NHS found it wanting in terms of its ability to

account for these central powers, making it difficult to consider the influence of a central directing state (i.e., a network of institutions that stabilize particular sets of practices).

Within the Saskatchewan context of health system governance, the King, so to speak, still has his head. The Ministry of Health clearly exerts power within the regionalized structure (i.e., it was the central government who introduced the RHAs, established the legislation and accountability frameworks that guide their work; organizes orientation and training sessions for the RHAs; nominates the community members who will serve on the boards, and so forth). A lens is required with which to consider the role and influence of this central power. I will thus use the Habermasian lens as a means to view an administrative state relating to public spheres, to support my considerations of the relationships among communities, publics, CANs, RHAs, and the Ministry.

Recognizing that power also operates through capillaries, however, and that the actors at various sites relative to the central state exhibit productive power, I want to keep the Foucaultian lens, to support fuller considerations of the practices of these central actors. I also want to carry Foucault forward as a tool to help understand the realities of the practices. Through this framework, I will analyze the meanings, interpretations, practices, and discourses captured through interviews with central actors in the governance and public participation models.

Foucault's work has also been criticized for its inability to provide (or, more accurately, for its lack of desire to provide) a normative ideal against which to compare reality. We are to interrogate every social arrangement for problems (Flyvbjerg, 1998), perhaps especially those put forth as ideals. This absence of an anchoring universal or ideal against which to measure the practiced, has led to charges (including from

Habermas himself, see Habermas, 1987b) that Foucault's work is relativistic and nihilistic, and that its attention to particular contexts and practices can blur our ability to see more generalized conditions (Flyvbjerg, 1998). To help anchor my work and buoy these charges, I will call on Habermas and his deliberative democracy as a normative ideal against which to consider actual practices, while remembering that

If our goal is to move toward Habermas's ideal—freedom from domination, more democracy, a strong civil society—then our first task is not to understand the utopia of communicative rationality, but to understand the realities of power (Flyvbjerg, 1998, p. 219).

Much has been written to compare and contrast the theories and positions of Foucault and Habermas (e.g., Ashenden & Owen, 1999; Biebricher, 2007; Flyvbjerg, 1998; Fraser, 1989; Habermas, 1987a; Ingram, 1994; Kelly, 1994), and while their works stand in opposition on many specifics, Biebricher (2007) urged using Habermas and Foucault together, overcoming the forced distance between their theoretical frameworks. In particular, he proposed (while recognizing the potential for many alternatives) using notions of governmentality to study projects fueled by Habermasian notions of deliberative democracy. Following Biebricher, I propose to carry forward both theoretical lenses as sensitizing frameworks within which to approach this investigation of regionalization and public participation within Saskatchewan's health system. Keeping these two frameworks in view simultaneously allows me to consider the tension between the centralized state as a seemingly stabilized structure, functioning as an actor in this debate, and the state as a network of capillaries of power.

## **2.7 Summary**

There has been much scholarly description of regionalization and many public participation conceptualizations and case studies, but a limited amount of critical scrutiny

and evaluation of this public policy innovation. There has been even less research centered on the interpretations and practices of the central actors themselves, exploring how these actors “do” (i.e., interpret, talk of, and practise) regionalization and public participation and what cultural elements are solidified and marginalized with these interpretations and practices. Between the formal announcements and the day-to-day practices of the actors who operationalise the policies, lie the interpretations and agency of actors, which both shape and reflect broader social and political forces within which their interpretations and practices are situated. This line of questioning has methodological implications that I turn to in the next chapter.

## CHAPTER 3: METHODOLOGY

### 3.1 Introduction

This study explores the interpretations and practices of actors directly involved in the implementation of a set of regionalization policies introduced into Saskatchewan's provincial health care system in 1992 and amended in 2001. In particular, this study examines how two interrelated initiatives (regionalization and public participation), came to be framed and practised by central actors who took the announcements (as scripted by the political-administrative state) and operationalized them, constructing the intention of the announcements and policies into actual, tangible, day-to-day practices.

Words such as “regionalization” and “public participation” are common parts of the discourses and practices of RHA members and other key actors within the governance and administration of Saskatchewan's health care system, and they are words that have come to have taken-for-granted meanings and understandings. Because discourses are more than simply words, however, and because discourses are themselves practices that carry with them the marks of what came before, and in turn come to influence what can and does come after (Brodie, 2008), stopping to analyze, consider, and critique discourses is an important exercise. Such analyses help in considering the everyday practices of the policy worlds within which decisions are made, and the larger socio-cultural-political worlds in which the policies, practices, and people are embedded.

This research was approached with three objectives:

1. Interpretations and practices of regionalization: to explore how actors framed and practised regionalization, including the reasons for its introduction, the roles and functions of the boards, and their roles and functions in relation to

the other actor groups. What do they “do” as health system governors? In addition to identifying the dominant, emergent, and residual discursive elements (Brodie, 2008; Clarke, 2007; Williams, 1977), attention is paid to the framing arguments and logics (i.e., where are democratically rooted intentions evident? Where are intentions that resonate with population health logics? Under what circumstances are technocratic logics called upon?).

2. Interpretations and practices of public participation: to explore how actors framed and interpreted public participation, paying particular attention to the themes of their discourses, as well as the rationalities and logics called upon to contextualize and explain public participation. Where are publics and communities called upon in the decision-making and governance models and in what capacity are they inserted into the governance and decision-making processes (e.g., as patients, citizens, hybrids, collectives, individuals, etc.)?
3. considerations of effect: to consider the plausible effects of these interpretations and practices on the roles and functions of these actor groups, on this governance initiative, and on broader social and political worlds.

These objectives organize the content for the remaining chapters. Before proceeding, this research needs to be positioned within its broader epistemological framework.

### **3.2 Ontological and Epistemological Positioning**

I situate my research within a critical-constructionist, social ontology and epistemology. I use the term “critical” to denote that my work questions the status quo and pushes for alternative interpretations of the seemingly mundane and routine, sensitive to uncovering practices that (re)produce inequities and occlude considerations of what

could be (Calhoun, 1995; Carroll, 2004; Crotty, 1998; Fairclough, 2001; Kincheloe & McLaren, 2005; Rogers, 2004; Van Dijk 1993). With this positioning, I am rejecting claims to neutrality and cooperation with the status quo (Carroll, 2004).

I use the term “constructionist” to indicate that I am not holding to a belief in only an external social reality that sits waiting to be uncovered and discovered. It exists, independent of us, and is real and affecting, but instead I attend to how these social realities come to exist, in part, through the construction and interpretation of actors (Crotty, 1998). In this way, my findings are not solely concerned with evidence of a discovered empirical reality, independent of actors. Rather, my research attends to the constructed meanings, shared discourses, and practices, all of which are also real in their effects as they contribute to the structure and patterns, and enable and constrain the actions of actors, now and into the future (Porter, 2004).

With this positioning, I reject strictly positivist, objectivist views of our social worlds; there is more to the social world than simply an independent, tangible, material. I also reject strict phenomenological, subjectivist interpretations that attend only to individuals’ meanings, ignoring the structures that affect the meanings (Porter, 2004). There is more to the social than simply our interpretation of it. There is a real and influencing external reality; the structures and patterns that are created and maintained in our interpretations, shared discourses, and day-to-day practices are also real.

In this way, I align with critical-realists (Denizen & Lincoln, 1998; Porter, 2004; Archer, 1998). I accept that there is a creative agent, and that not all can be reduced to the human and her consciousness; real social and material conditions affect (both enabling and constraining) her consciousness. Furthermore, her actions may have effect beyond



her intentions and time (Porter, 2004). Like critical-realists, I orient my work toward the study of this structuring of actions, and towards the uncovering of those structures and patterns that affect our freedom (Porter, 2004).

Finally, I approach this inquiry within a sociological paradigm and, in particular, with an assumption that there is both a “social” that structures and shapes (and is influenced by agency) and an “actor” with creative agency who is influenced, constrained, and enabled by structure (Giddens, 1976). While recognizing interpreting actors and their agency, I also attend to the social and the structures, practices, tendencies, and patterns that exist in our world and that interact in mutually constitutive ways with our productive agency.

### **3.3 The Methodological Relevance of Discourse**

The analysis of discourses provides a legitimate means through which to access social worlds, tendencies, patterns, and structures (Bazerman & Paradis, 1991; Fairclough, 2001; Rogers, 2004; Smith 1986, 1990, 2005; Van Dijk 1993). Accordingly, I approach language not simply as a series of words and utterances but as “discourses,” sets of social practices that produce and reproduce social structures (Fairclough, 2001), influencing us, but not completely determining us (Berger & Luckman, 1971). In terms of their productive forces, discourses not only relay interpretations and accomplishments, but also serve to regulate what can be spoken, written, heard, and understood (Foucault as cited in Smith 2005, p. 18). In other words, discourses make “reality thinkable” (Rose & Miller, 1992, p. 179). Discourses are not only the accomplishments of complex activities, but also serve to stabilize accounts of reality (i.e., they themselves become structures) and thus influence future actions (Bazerman & Paradis, 1991). In this way, texts (written and

spoken, formal and informal) are approached as windows into how actors think, know, and understand their world (what is being stabilized and (re)produced through these texts), and as rear-view mirrors through which to see the larger institutional discourses and rationalities that shaped their production (i.e., the effects of previously stabilized discourses that affect the present). Language is not simply an individual choice; it is socially rooted (Fairclough, 2001). From this positioning, language and discourse can be approached as conduits between structure and agency, between the macro and micro, and thus as highly relevant sociological focal points.

To the broad methodological positioning described above, I add three comments. First, I am interested in exploring the discourses (as the practices they are and the structures they reveal) of central actors in the regionalization governance models being enacted in Saskatchewan. While shifts in the logics and rhetoric of the formal, scripted texts announcing regionalization and public participation practices in Saskatchewan in 1992 and 2001 are evident in government documents, it is not known to what degree these logics and shifts are reflected in the interpretations and practices of the people who have since enacted these texts. I want my examination of regionalization and public participation practices to be situated in *their* discourses (i.e., the understandings, framings and interpretations of central actors who have helped to fashion the practices from these of policy announcements and thus who are helping to fashion practices of the central, administrative state, or at least the RHA). Analysing *their* interpretations and practices helps in evaluating dominant, residual and emerging elements to these governance models, and in identifying new norms of relating within shifting lifeworld-system interfaces. Thus, I want to hear from these actors and am interested in adding *their*

practices to the picture of health system governance and regionalization models. By better understanding the practices of people actually “doing regionalization,” one can more fully understand these organizations and the social structures within which they operate, and can identify larger ideas, social concepts and forces that are at play, helping to fashion and stabilize their meanings, interpretations, discourses and practices of regionalization and public participation within Saskatchewan’s health care system.

Second, as will be seen in Chapters 4 and 5, the policies of regionalization and public participation, and the governance models that resulted, came to be interpreted and practised within complex contexts, wherein competing and overlapping interpretations and understandings have developed. Rather than approaching the discourses as meta-narratives, I draw on the work of Brodie (2008), Clarke (2007), and Williams (1977), and use their notion of dominant, emerging and residual discursive elements to consider the themes and logics that appear within the interview data in a more nuanced manner. From Williams, “dominant” refers to the most affecting, determining, influencing and hegemonic elements of a culture. Hegemony, as Gramsci (1971) observed, is not a static phenomenon; consent must be “won,” and therefore dominant discourses are continually reformulated in response to political challenges and changing economic and social conditions. “Residual” refers to cultural elements formed in the past but that continue to have influence in the present (e.g., the liberalism in neo-liberalism, the conservative elements in neo-conservatism). These residues become threads that contemporary governing strategies, in order to be stabilized, need to “displace, incorporate, or marginalize” (Clarke, 2007: 982). “Emergent” elements are those new ideas, conceptualizations, and practices (Clarke, 2007) that surface from points of “friction,

possibility, and resistance” (Brodie, 2008: 151) with the dominant, and that may reflect either new phases of, or alternatives to, the dominant discourses (Williams, 1977).

Third, I am not interested in testing hypotheses about the efficacy of regionalization or public participation. Nor am I interested in completing a historical reconstruction of regionalization and its changing models, asking what changed and why. I am interested in exploring the discourses of central actors to identify the dominant, emergent, residual, and absent themes in their framings, and doing so from theoretically informed positions. Although my methods are qualitative and allow for exploration and induction, from early stages of this project I have been rooted in theoretical conceptions influenced by Habermas, with his dualistic theory of society (with a system and lifeworlds), and his normative ideals for deliberative relations between public spheres and the political-administrative state. To this, I have added Foucaultian notions of studying actual practices, of seeing power as de-centered and operating in all relations, of remaining skeptical of guiding rationalities, and of interrogating practices to see how they contribute to domination, even those embedded within potentially empowering and democratizing policy initiatives.

Before proceeding to my specific methods, it is important to clarify that the focus of this research is not about particular individuals, nor is my concern to explain individual behaviors. I approached the interview data as reflections of the interviewees’ interpretations and experiences, *and* as entry points to structures and processes operating beyond their immediate social realities and interpretations (Smith, 1986; 2005). Section 3.5.1 details the quality checks applied to this project to ensure a rigorous exploration.

### **3.4 Methods**

Having articulated the methodological positioning for this dissertation, I now turn to the specific methods that supported the research. As stated earlier, I was committed to beginning with people on the front-line of this governance innovation in Saskatchewan (i.e., the central actors significantly involved with interpreting the policies and fashioning productive practices from them). In particular, I was curious to see how these actors framed, interpreted, and practised health system regionalization and its related theme of public participation. How did these actors talk of the innovations? What dominant, residual, and emerging elements can be identified with their discourses? What logics did they call on? This information would then support critical considerations and discussions of their plausible implications.

#### **3.4.1 Document Reviews and Interview Preparation**

Before interviewing central actors, I reviewed key documents detailing regionalization and public participation within Saskatchewan's health care system. This reading helped to extend my understanding of the general and specific regionalization and health reform history in Saskatchewan, and the specific changes in the stated roles and responsibilities of the health boards as they transformed from the 400 plus facility boards to the 32 DHBs, and then to the 12 RHAs (with CANs). In these readings, I paid particular attention to how the boards, authorities and networks were articulated in terms of their representation of and relations with publics and communities. Appendix A lists the documents reviewed during this phase.

In addition to providing historical detail and understanding, this phase of research also helped me to prepare for the interviews that would take place in phase two of the

project (Mason, 2002, p. 105), ensuring appropriate use of terminology, sequencing of historical events, and so forth. During this preliminary phase of the research, I also attended the public portion of two RHA meetings to better inform me as to the routines and practices, and to prepare me for the interviews.

#### **3.4.1.1 Hansard Transcripts**

To familiarize myself with and to better understand some of the larger political discourses, rhetoric, and ideologies within which these policies were planned, scripted, and announced, I reviewed the *Debates and Proceedings of the Legislative Assembly of Saskatchewan*, for the 22<sup>nd</sup> to the 24<sup>th</sup> Legislatures. This material encompassed the Legislatures within which the 1992 reforms and the 2001 amendments were announced. All nine legislative sessions (the five of the 22<sup>nd</sup> Legislature, running from December 2, 1991 to May 18, 1995 and the four of the 24<sup>th</sup> Legislature, running from December 6, 1999 to June 27, 2003) were searched using the search term “health.” Each health reference was read for relevance and context (i.e., health questions, debates and speeches related to health reform, regionalization, changes in governance models, and references to public, citizen and community engagement and control).

In addition to the daily transcripts of any speeches, questions, answers, and debates of Members of the Legislative Assembly, Hansard (as these transcripts are commonly referred) includes the Throne Speeches made by the Lieutenant Governor at the opening and proroguing of Legislative sessions. These speeches summarize the government’s intentions for the session ahead and provide a synopsis of the achievements from the proroguing session. The speeches for the 22<sup>nd</sup> to the 25<sup>th</sup> Legislatures were reviewed for references to health system regionalization and public participation. The

findings of this review are presented in Chapter 4, and represent the formal announcements of the changing direction of government policy.

### **3.4.2 Interviews with Central Actors**

After completing the document reviews, and after receiving approval by the University's Research Ethics Board, I moved to the second phase of research, the interviews. This phase consisted of semi-structured, one-on-one interviews with consenting people from across four groups of actors: RHA Chairs, health region CEOs, current and former Ministry of Health representatives involved in designing and implementing health boards, and CAN members.

Interviews were conducted in the summer of 2008, between June 18 and August 20. Of note, at the time of interviewing there was uncertainty as to the future of RHAs in Saskatchewan, their compositions, roles and functions. In addition, the NDP, which had been in power for sixteen years, lost the 2007 election to the Saskatchewan Party, a new configuration of the Conservatives. There was speculation as to what, and when, changes might happen in health in general and with the RHAs in particular. Also contributing to this curiosity and tension was the fact that Alberta had de-regionalized its provincial system in the spring of 2008, disbanding its RHAs and forming one provincial board. These events helped contribute to a sense of intrigue and concern that was palpable during most interviews. Several of the interviewees were sensitive to what was being said publicly about health regions and their roles, and sought reassurance that their identified words and opinions as shared during the interviews would not enter that fora, intentionally or unintentionally. Other interviewees were not concerned, and indeed, were quite vocal that they would like to share their opinion. Almost all people interviewed

volunteered opinions, before, after, and during the interviews, as to what they hoped, wished and feared for health regions, governance structures, accountabilities, and health reform in general. Several interviewees were very reflective in their interviews, indicating that they believed the interviews were likely part of their final tenure.<sup>21</sup>

#### **3.4.2.1 Sampling and Contacting Interviewees**

The general procedure I used to compile the purposive interview sample was to identify individuals whom I wanted to interview and a contact address, and then send them a letter of invitation (Appendix B) and consent form (Appendix C), introducing myself and the project, and asking them to contact me if they had questions or would like to participate. In cases where an address was not publicly available, phone calls were made to identify an address to which the letter was sent. Once people had decided as to whether they would like to participate, a mutually agreeable interview time and location was established. Specifics and exceptions to this procedure are discussed below.

RHA Chair Interviews. Although RHA members and Chairs are public figures, with two exceptions, contact with the Chair was directed through the executive offices of the region. While names and photos of board members were typically available on region web sites, only two regions listed contact details for board members. In these two cases, I used this information either to send a letter of invitation to the Chair or make a phone call to the Chair in which I introduced myself and the research, soliciting a contact address to which I could send the formal letter of invitation. Contact with the remaining chairs, however, was routed through the executive offices. In these 10 cases, phone calls were made to the offices explaining the research and my desire to contact the RHA Chair. A

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<sup>21</sup> As a post-script, in February of 2009, the government announced its appointments for the RHAs. Of the RHA Chairs interviewed in this study, six remained as board members (although not necessarily as Chair). Changes to the form and function of the RHAs are still unannounced, but anticipated.



preferred method of contact was then established. In most cases, the assistants requested either that an email be sent to her for forwarding to the Chair, or that a letter be mailed to the office for her re-routing to the chair. In some cases, executive assistants provided direct contact details, at which point emails or letters were then sent to the chair. In one case, I was asked to have my research vetted through an internal review process for health region staff to assess research burdens on health system sectors (in this case the board) before I could approach the Chair.

I share this information not only as process detail but also as it speaks to the alleged democratic and representative nature of the boards. The Chairs were not publicly accessible, and were perhaps protected by barriers erected between boards and publics.

At the time of writing, Saskatchewan has 12 RHAs (not including the Athabasca Health Authority that has different governance and reporting relations due to tri-partite arrangements between the First Nations, Federal government and Province). My intention had been to interview all 12 Chairs (or their chosen designates). I interviewed 11 Chairs, being unable to successfully contact or secure the participation of one Chair.<sup>22</sup>

Although my primary interest is in the interpretations and practices of members of the RHAs, to help create a more complete picture, I also interviewed consenting health region CEOs, Ministry of Health representatives (both current and former affiliates, central in the design or enactment of the 1992 and 2001 policies), and CAN members. In addition to historical and broader contextual details, these interviews helped provide a preliminary but detailed exploration of some of the potentially competing and shaping visions and interpretations of these influential agents whose understandings of the roles

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<sup>22</sup> I used the same protocol to reach this Chair. In the case of this one Chair, none of my contact attempts were returned. In order to respect his/her right not to participate, no further contact attempts were made.

and functions of the various groups undoubtedly influence the practices and experiences of the community governors and public participants.

CEO Interviews. I sampled CEOs across urban, mid-sized, rural, and northern health regions, compiling a purposive sample to achieve a representation of CEOs. CEOs were contacted via email. In some cases, this email was followed with a letter mailed to their office or hand delivered to them at a local health conference. I proposed a minimum of three CEO interviews and completed eight.

Ministry of Health Interviews. Ministry interviewees were secured via a purposive sample generated after reviews of organizational charts and portfolios, and in consultation with other informed actors. I was specifically looking to interview people who were as senior as possible (Minister of Health, Deputy Minister, Assistant Deputies, and Directors), with portfolios that included substantive work with the health regions, tenures that ideally extended across the two points of reform (1992 and 2001), and who were identified in consultations as historically influential agents. Once the ideal sample was identified, I sent emails of introduction to their work addresses, and in some cases followed up with a letter hand delivered to them at a local health conference. I had proposed a minimum of four Ministry interviews and completed eight.

CAN Interviews. A different process had to be used for identifying and contacting CAN members. Their names and contact details were not publicly available through the health region website. CAN contacts were thus facilitated by the health regions with the following procedures.

While CANs are mandatory in the legislation, not all RHAs have CANs established (some have tried and stopped, some have opted to use alternate networks,

etc.). Going into the interviews, I was aware of regions that had CANs functioning (as detailed in their Annual Reports, on their websites, etc.) and sampled across these to ensure inclusion of urban, mid-sized, rural, and northern CANs. During interviews with the Chairs or CEOs for these regions, permission to contact a sample of their CAN members was solicited, and interviewees were asked if they would be willing to provide the name and contact details for between one and four CAN members. Chairs or CEOs then contacted these individuals, requesting permission to share contact details with the researcher. Once permission was granted and contact details were shared, I contacted CAN members either by email or phone, and introduced myself and the study, and asked permission to send a letter of invitation. My intention had been to interview six CAN members from at least three different networks and regions. I was not able to secure the participation of two CAN members that I contacted and ended up with five interviews. One contact informed me that s/he had resigned from the CAN earlier that week, frustrated with its apparent limited role and thus was not comfortable being interviewed.<sup>23</sup> The other, after scheduling, cancelled our appointment (for personal reasons unrelated to the nature of the research) and a reschedule was not possible.

### **3.4.2.2 Sample Summary**

In total, I interviewed 32 people. With the possible exception of the five CAN members, the 27 remaining interviews were with individuals in highly significant positions relative to Saskatchewan's health governance model. This sub-sample of 27 people includes some of the most plausibly influential players and strategic actors in the governance models designed and enacted in the province. What RHA Chairs, health

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<sup>23</sup> Interestingly, in February 2010, an entire CAN resigned in frustration over an apparent failure of the health region to communicate with them (Scissons, 2010a).

region CEOs, and senior Ministry of Health officials think and do, their interpretation and constructions of the roles and functions of the different groups, and their relations to each other have a significant potential to influence what gets done, by who, and, in general, how roles are enacted. Table 3 summarizes the proposed and secured samples.

Table 3: Proposed and Secured Interview Samples

Actor Group	Proposed	Secured
RHA Chair (or designate)	12	11
CEO (or designate)	$\geq 3$	8
Ministry of Health	$\geq 4$	8
CANs	6	5
Total	$\geq 25$	32

### 3.4.2.3 The Interviews

Each person was interviewed once. Before beginning the interview, the consent form (see Appendix C), as approved by the University of Saskatchewan’s Research Ethics Board, was reviewed with each potential interviewee to ensure understanding of his/her rights as a research participant and to ensure that s/he was willing to (a) complete the interview, (b) have the interview digitally recorded, and (c) allow information shared in the interview to be used in the research with his/her direct statements reported on once potentially identifying information was removed. After securing informed consent, the recorder was turned on and the formal interview began.

Interviews were designed to last between 60 and 90 minutes, and individuals were asked a range of questions related to how they understood and experienced the roles and functions of the different groups of actors (RHAs, health region staff, Ministry of Health and CANs), and the logic of public participation in health system decision-making. I also included questions to ascertain aspects of their biographical and historical

situations, as well as relevant historical detail in the introduction and changing of health boards. An exception to this interview design was the CAN interviews. They were shorter interviews as I did not query these individuals in regards to the broader history of health regions in Saskatchewan or the roles of health region staff and Ministry. Based on pilot interviews with the first two CAN members I interviewed, I decided to eliminate this line of questioning from this group of interviews, as they seemed unaware of the broader context within which CANs and RHAs were positioned. Appendix D includes the interview guide for RHA interviews (a modified version of which was developed to guide interviews with CANs, CEOs, Ministry representatives). This interview guide was added to and refined based on the results of pilot interviews.

Although the interview guide lists the questions in a particular order, not all interviews proceeded in this sequence. To help minimize possible ordering effects of questions and any unintentional shaping, leading, or cueing my questions could offer (e.g., unintentionally increasing an interviewee's use of terms like "community," "democracy," or "public participation"), and to allow for a more natural flow to the interview conversation, I was flexible in interview question order. All questions were asked in ways to encourage open-ended answering, that minimized leading with my expectations or assumptions, and that were non-judgmental in word or tone.

Thirty-one of the interviews were face-to-face; the remaining interview was completed by telephone. Eighteen of the interviews took place in health region space, 6 in the interviewer home, 5 in a workplace, and 2 on a university campus.

All interviews were recorded digitally. The recordings ranged in duration from 33 to 105 minutes, with an average of 75 minutes. Non-CAN member interviews ranged

from approximately 44 to 105 minutes, with an average of 82 minutes. As there were fewer questions asked of CAN members, their interviews were shorter and ranged from approximately 33 to 56 minutes, with an average of 42 minutes.

Shortly after completing each interview, I listened to the digital recording, alongside any written notes that I had produced during the interview and immediately after in a post-interview log. These notes were added to during this listening. In addition to general notes and ideas, I paid particular attention to “surprises” in the content of each interview, ideas or possible themes that I might want to consider in future interviews, as well as my interviewing technique, so as to further strengthen my interviewing skills (e.g., use of open-ended questioning, not unintentionally leading respondents or encouraging sub-topics or themes, thorough probing, monitoring to ensure that my ideas and assumptions were not shifting the interviews or the sub-topics, etc.).

All but one interview felt authentic and no concerns were raised that perhaps individuals were not being truthful, that they were intentionally calling only on rhetoric, or were deliberately intending to mislead the researcher, and so forth. However, one interviewee called heavily on rhetoric, and by times sounded insincere, as though trying to convince the researcher of the merits and potentials of regionalization and public participation, and her/his support for the policy. It is unclear why this may have been the case, and to say more would only be speculative. In counter-point to this interview, another interview was extremely candid in responding to the questions, providing answers that were, by comparison to the majority of the other interviews, blunt and unguarded (e.g., not protective of the policies and practices). The remaining interviews fell in between these extremes, and in general were well received and productive.

#### **3.4.2.4 The Transcripts**

Recordings were transcribed verbatim. Discourse analyses vary widely in terms of the unit of analysis. With my analysis, I am attending to the shared discourses that appear across the interviews, not the individual utterances or speech styles and techniques. Thus, during the transcription process, I did not attend to details such as length and position of pauses, stutters and stammers, interruptions, and over-speaks (cases of these latter two were simply transcribed as two separate speech acts). Transcriptions were checked for accuracy against the original recordings. I then listened to each recorded interview alongside its printed transcription and my field notes (written before, during and after interviews). This listening marked the third hearing of the interview and helped to further familiarize me with the specific tones and ethos of interviewees' spoken words, and also helped transition the study from data collection stages to the recursive processes of data analysis and interpretation. Each transcript was read and reread several times so I could immerse myself in the data, and to facilitate my transition to the deductive and inductive thematic analysis of the research. As well, I pulled in my field notes and reviewed these several times throughout the analysis process.

#### **3.5 Data Analysis**

Once the transcripts had been completed, I moved to topic coding (Richards, 2005), where interviews were broken out into separate categories of text, as they related to my *a priori* categories and topic areas. Transcripts were coded and analyzed according to the discursive topics of (a) meanings and interpretations of "regionalization" and of the roles, functions, and specific practices of the RHAs and the other groups (i.e., health regions, Ministry, CANs and publics); (b) meanings and interpretations of "public

participation,” including who the “public” were and how and when their participation was or should be sought; (c) descriptions of self; and (d) the sensitizing concepts (Charmaz, 2005) of technocratic logics, democratic logics, population health logics, and governing mentalities. I also added (e) coding nodes for inductive themes that emerged in the interviews, and that possibly fell outside deductive, a priori nodes. Coding across domains was not exclusive, and much text ended up in multiple categories.

After completing the first round of topic coding, I completed a round of analytical coding (Richards, 2005) wherein I considered the implications and interpretations of the discourses, moving up from data to theory (inductive considerations), and down from theory to data (deductive considerations).

I used NVivo qualitative data analysis software to support my coding. Interviews were coded twice to ensure reliability of categorization. Once categories were created, their texts were read both independently and as part of their larger interviews. Domains were then considered in terms of themes, sub-themes, exceptions and contradictions, and patterns within and across interviewer type (e.g., Chairs, males, long tenure, rural, etc.). Although the interviewing process (data production) and the coding and interpretation of the interviews (data analysis) is presented in this text as two separate stages, in reality, the two were not mutually exclusive stages. As is expected and encouraged in qualitative work (Mason, 2002; Richards, 2005), the analysis was an iterative process that began as the first interview was being conducted and continued through the completion of writing. I moved in and out of the stages of production and analysis, and in and out of the stages of topic and analytical coding. In addition to topic and analytical coding, I also completed a process of comparative analysis to extend and deepen my consideration of the interviews



and the data nodes. At this stage, to heighten considerations and comparisons, I selected maximally contrasting interviews (e.g., rural or northern interviewees versus urban interviewees, male versus female, long versus short tenure, prior health care experience versus none, appearing relatively satisfied and content with regionalization versus dissatisfied and discontent, or calm versus agitated).

### **3.5.1 Ensuring Quality Research**

My positioning within a qualitative framework is not as a positivist (nor a post-positivist) searching for the average or common experience with which to establish patterns and causal relations among variables and phenomena, while attending to the reliability and validity in methods, data and interpretations. Cook and Campbell's (1979) classical yardsticks for social scientific research (i.e., internal validity, external validity, statistical conclusion validity, and construct validity) cannot be overlaid onto all qualitative projects (Bentz & Shapiro, 1998; Guba & Lincoln, 2005; Leninger, 1994; Richards, 2005). Thus, I am not monitoring whether my sample was representative and collected with no selection biases; whether every interview was conducted in precisely the same way with exacting stimuli provided to each interviewee prior to their recorded response; whether my data was coded with acceptable inter-rater reliabilities; or whether alternative contributing variables have been controlled or excluded from influence. This statement is not to suggest, however, that I am unconcerned with the rigor, richness, and quality of my data and interpretation. To ensure a rigorous and rich study, I stopped at several points throughout the interviewing (data production), data coding (data description) and data analysis (interpretation) stages to consider the following issues:

1. Systematic collection: I insured that my data was systematically collected (Charmaz, 2005; Denzin & Lincoln, 1998; 2005). A standard interview guide was used. I attended to collection details such as establishing rapport with the interviewees and noting factors that may have hindered my or an interviewee's focus, honesty, candor, etcetera.
2. Detailed data: I insured that my data was detailed (Charmaz, 2005). I used a recorder to capture the interviewee words in their entirety. Spoken texts were transcribed verbatim. I recorded field notes during and after interviews and considered these notes during transcription and iterative analyses.
3. Rich data: I insured that my data was rich. I needed to ensure that I reached saturation in interview content and that no new ideas or concepts were being shared during my last series of interviews. I had committed *a priori* that new interviews would be added to the sample if saturation were not achieved. I needed to ensure that the data of this study would bring new details to the public record about the phenomena under study. I also needed to be aware of the broader social, cultural, political and historical contexts within which the data were produced (Bentz & Shapiro, 1998; Charmaz, 2005)
4. Good sample: I ensured that my data were collected from a "good" sample. This was not defined in terms of how representative the sample was of a larger population, but was defined in terms of whether a range of voices and experiences were represented in the sample and data (Charmaz, 2005).

Once collected, my concerns with quality shifted to ensuring that my data was subjected to rigorous and thorough analyses. To support this:

1. I used an in-depth and extended data analysis process, wherein questions and data nodes were analyzed iteratively.
2. I sought confirming and disconfirming cases (Frankel, 1999), and cases that countered my expectations and biases. I tried to remain aware of how my biases could be affecting what I saw and heard (Bentz & Shaprio, 1998).
3. I ensured that my analysis did more than simply describe data and instead took the descriptions as a starting point, moving from there into interpretation (Richards, 2005),
4. I ensured that interpretations and questions raised with my data and analyses were useful, adding to our understanding of the phenomenon under investigation (Bentz & Shapiro, 1998; Charmaz, 2005; Crotty, 1998; Frankel, 1999; Richards, 2005), and bringing new knowledge to the table to add to our consideration and critique (Charmaz, 2005; Crotty, 1998; Kincheloe & McLaren, 2005). Finally,
5. I revisited the interview transcripts in their entirety throughout several stages of analysis to ensure that my themes and interpretations continued to resonate with the larger interview and that the details and themes I was highlighting continued to be visible and relevant to their interpretation.

### **3.6 Sample Description**

Before turning to the next chapter and its presentation of data, I want to detail who it is that completed these interviews, in terms of their socio-demographic backgrounds and some of their biographical details. As part of the interview, each of the interviewees completed a socio-demographic sheet (Appendix E). Table 4 summarizes

their data as a whole and for each actor group (Chairs, CEOs, Ministry staff, and CAN members). From the final column of Table 4, a range of region sizes can be seen represented in the sample, with range as well across sex and other socio-demographic characteristics (e.g., number of dependents, education, employment field and economic status). It is important to note, however, that there was limited range across age (only one interviewee was less than 35 years of age), ethnicity (only three interviewees identified as non-Caucasian), marital status (only two were not married or in common-law relationships), and income (only one reported an income of less than \$25,000).

From Table 4 it can be seen that as a group the Chairs tended to be white, older (55 plus years), married men, with no dependents. They tended to work outside of health, were not university educated, and did not report low incomes (i.e., <\$25,000). The CEO group also tended to be white and married, but were younger, with more women being represented and, perhaps not surprising given their ages and genders, more reported having dependents at home. They were university educated and reported higher incomes. The small Ministry sample consisted of white, married men with university educations and no low incomes. And finally, the small number of CAN members interviewed consisted of women and men who were white, married, older, with no dependents. As with the Chairs, the CAN representatives tended to work outside of health and were not university educated. Their demographics did show some representation from otherwise unrepresented age and income groups (i.e., people less than 35 and living in households with annual incomes less than \$25,000).

Table 4: Socio-demographics for Interview Sample By Actor Group and In Total

	Chairs	CEOs	Ministry	CANs	Total
<b>Region</b>					
Urban / mid	5	5	0	3	13
Rural / northern	6	3	0	2	11
Provincial	0	0	8	0	8
	11	8	8	5	32
<b>Sex</b>					
Female	3	3	2	3	11
Male	8	5	6	2	21
	11	8	8	5	32
<b>Age (years)</b>					
<35	0	0	0	1	1
35-54	1	3	3	1	8
55+	10	4	4	3	21
Did not respond	0	1	1	0	2
	11	8	8	5	32
<b>Visible Minority</b>					
No	10	7	8	4	3
Yes	1	1	0	1	29
	11	8	8	5	32
<b>Common-law</b>					
Yes	10	8	8	4	30
No	1	0	0	1	2
	11	8	8	5	32
<b>Number dependents</b>					
0	8	2	3	4	17
1+	3	5	4	1	13
Did not respond	0	1	1	0	2
	11	8	8	5	32
<b>Highest Education</b>					
University	2	7	8	0	17
College or tech	5	1	0	2	8
High school/other	4	0	0	3	7
	11	8	8	5	32
<b>Employment Field</b>					
Health	3	na	na	1	15
Other	8	na	na	4	16
Did not respond	0	na	na	0	1
<b>Employment Status</b>					
Self-employed	4	0	0	1	5
Full time	3	8	8	1	20
Part time or other	4	0	0	3	7
	11	8	8	5	32
<b>Income</b>					
\$100,000+	4	8	0	0	19
\$25-100,000	5	0	8	4	10
<\$25,000	0	0	0	1	1
Did not respond	2	0	0	0	2
	11	8	8	5	32

In addition to the socio-demographic sheet, I opened each interview by having the interviewee introduce herself. The typical opening question was: “Let’s begin by having you share a bit about yourself and your work with health and health regions. Who are you? What is your role? How long have you been here?” Depending on response, probes might follow such as: “what is your professional training and background?” “Have you served on other health boards?” “Have you worked in other health portfolios?” “Why did you agree to this role?” In general, I was able to apply consistent questioning, with minor variation to accommodate depth of response, facilitate rapport, and add clarity.

Ten of the Chairs interviewed had served on their RHA since its 2002 inception, with nine having been involved since the inception of the original DHBs (five as elected members). At the time of the interview, six of the Chairs interviewed had served as Chair since the inception of the RHA, three had served as Chair for 1 to 6 years, and two had served as Chair for less than 1 year. Eight of the Chairs interviewed had also served as Chair for some portion of their prior tenure with a DHB, with three or fewer<sup>24</sup> having been Chair since the very inception of the DHBs. Table 5 summarizes these figures.

Table 5: RHA Chair Tenure with Health Boards in General and as Chair

	Since RHA inception	Since DHB inception
On RHA	10 of 11	9 of 11
Serving as Chair	6 of 11	n<=3 of 11

In terms of how the Chairs came to be on the RHA, given the nature of the board appointment process, all 11 were appointees. Five of these Chairs, however, had been elected to the former DHBs, and an additional two had been elected to municipal council and from there were appointed to the DHBs.

<sup>24</sup> To help preserve anonymity for my sample, frequencies and cells of fewer than four are not reported in any more detail than “less than or equal to three.”

Three Chairs had local elected political experience (e.g., through RM or City Councils). All but one cited some level of organized community involvement (e.g., volunteer with recreation boards, church or school groups, or pre-regionalization health boards). All but one cited prior board experience outside of health. Outside of their current role with the RHA or their former roles with DHBs, 10 of the Chairs interviewed cited other health involvement (e.g., work in health care, volunteering for facility boards, and serving on provincial and national health-related organizations).

In terms of why they were involved, five cited a general interest in health and health care, three cited an interest in what they saw as the administrative and financial challenges facing health facilities and boards, two cited personal encouragement by their community to serve on their behalf, and one cited personal concern over possible health care changes. Table 6 summarizes these details.

Table 6: Synopsis of RHA Chair's History

Detail	Number (of 11)
On board since RHA inception	10
On board since DHB inception	9
Serving as Chair since RHA inception	6
Serving as Chair since DHB inception	n<=3
Elected to former DHB	5
Elected to Municipal Council and then appointed to Board	n<=3
Elected to Municipal Council	3
Prior health care work experience	3
Business experience	4
Professional financial training	n<=3
Organized community involvement	10
Board of Director experience	10
Other health involvement	10
Involved from health or health care interest	5
Involved for admin and financial challenge	n<=3
Involved with community encouragement	n<=3
Involved from personal concern over possible health care changes	n<=3

The eight CEOs interviewed had served in their current positions between 2 to 6 years. All had prior health experience (i.e., before their current posting as CEO), and these priors ranged from front-line service provision (n<=3), to administrative postings (n=7), to senior leadership positions (n=8). This group also had prior experiences that included facility level postings (n=8), health district postings under the former DHB model (n=6), health region postings other than their current CEO post (n<=3), provincial postings (n<=3), and out-of-province postings (n=4).

The eight Ministry staff interviewed (who represent but a small number of the total group, but who do represent key postings) had served in their current positions from times ranging from less than 1 year to close to 10 years. Outside of their current post some individuals had served in prior Ministry of Health posts (n=5), had experience with the former DHB structure (n=5), or were involved in the formation of DHBs (n=3). In terms of their experience with the RHA structure, most (n=5) had been involved during the inception of RHAs, with the remaining coming on soon after the regions were in place. A number (n=5) of the individuals interviewed were no longer with the Ministry.

The five CAN members interviewed represent but a portion of the total group, the total number of which is unknown. They had served with the CAN for between 1 and 8<sup>25</sup> years, and had attended between 1 and 8 meetings, that ranged from 2 hour meetings to day long sessions. Three of the CAN members had come to the position through involvement with a municipal council. Their reasons for joining included: interest in health (n=2), wanting opportunity for input (n=2), to learn about health (n=1), to help with their work (n=1), to meet people in the system for possible career contacts (n=1), that they liked to volunteer (n=1), and that they wanted to help reform the system (n=1).

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<sup>25</sup> Some regions had established advisories prior to the 2001 introduction of RHAs and CANs.



### **3.6.1 Sample Summary**

In general, the interviewees represented a mature and experienced group of individuals. Most of the Chairs have deep roots in the health boards, extending back to the DHBs and even earlier, with the majority of them being experienced RHA and DHB Chairs. These Chairs are active and engaged in their communities.

In terms of the range of voices heard from -- an issue of interest in a qualitative exploration -- it needs to be explicitly noted that I heard from a variable but somewhat restricted range of voices. It cannot be known whether the findings I report in subsequent chapters would have been repeated had I heard from a more diverse group, but then again, whether such a group even exists within this population is unknown. But while some of these numbers may be an artifact of sampling for the CAN members and Ministry staff, where so few of their population was sampled, the same cannot be said of the Chairs and CEOs. The 11 Chairs and eight CEOs interviewed comprised 92% (11 of 12) and 67% (8 of 12) of the total number of Chairs and CEOs in Saskatchewan, and thus are representative of their total populations. With the addition of the Chairs, and more so with the CANs, there is some, albeit limited, range and variability being added to the group of discourse elites within health system governance in Saskatchewan.

### **3.7 Summary**

In this chapter, I have outlined the objectives and key questions for this study, and have provided a detailed discussion of the methodological positioning of this work. Discourses matter, and are relevant for sociologically informed explorations of public policies. Central actors' understandings of regionalization and public participation influence subsequent constructions of practices. Their understandings and interpretations

of these policies form mutually constitutive relationships with the practices they as actors (re)produce, which in turn shape future understandings and interpretations, marginalizing some elements of practices while heightening others.

I have also detailed who completed the interviews (32 central actors in the governance of Saskatchewan's health care system – 11 RHA Chairs, 8 CEOs, 8 MoH senior executives and officials, 5 CAN members). A range of voices was heard from in the interviews, an important feature in qualitative research, but cautions are raised as to the degree to which these groups represent larger groups.

Finally, this chapter also detailed the specific methods that I applied to the data from the interviews. Having laid the methodological foundation and having detailed my methods, I turn to the next two chapters and the interview data itself, analyzing the texts produced in the semi-structured interviews, listening for patterns and themes across and within the four sub-groups, and listening for notable exceptions and variations within.

## **CHAPTER 4: CONSTRUCTIONS AND REFLECTIONS OF TECHNOCRATIC LOGICS**

Saskatchewan's health care system is comprised of a densely populated field of federal, provincial, First Nations', regional, and local groups and organizations, each with distinct but interrelated roles and functions. This research focused on the more centrally positioned groups, those comprising a formal governance level of the provincial health care system and most directly linked to various publics and communities (as opposed to, for example, organizations with primary linkages to labour groups or service providers). Through the legislative reforms of 1992 and 2001, sub-provincial health regions were created to serve as geopolitical spaces through which health care services are planned, organized and delivered, with oversight from RHAs (and before them, DHBs). Given their seemingly pivotal role in the health care system and their potential to serve as sites of innovation, institutionalizing communities and publics in the governance of local health care services and systems, the RHAs were the prime focus of this research.

Throughout the research interviews, central actors routinely (and perhaps habitually) described RHAs as "governance boards." Interesting tensions emerged, however, when then comparing the specified roles and functions of the RHAs to definitions of governance. Governance refers to the act of governing; the act of directing, controlling and regulating (Oxford English Dictionary, 2000), and includes purposeful acts carried out in an effort to guide, steer and control a body (Prince, 2001). The interviewee descriptions of RHA roles and functions indicate that many of the formal and informal structures and relationships were practiced in ways that mitigated an RHA's authority to direct and steer (and thus govern).

Related to these contradictory governance practices, central actors portrayed RHAs as accountable for their decisions, but this accountability was to the Minister and Ministry, rather than communities and publics of the region (accountabilities highly touted during the 1992 reforms). Accountability is a critical component of governance and refers to the state of being liable to give an account for conduct and the discharge of duties (Oxford English Dictionary, 2000). Fooks and Maslove (2004), in reviewing accountability within the Canadian health care system identified six defining elements: relationship (a connection between the decision-makers and the affected); responsibility (for decisions and actions); authority (to conduct and to delegate); answerability (for decisions); performance (a concern with the quality of the decisions and results); and sanction (for poor performance). The data from these research interviews depicted RHAs as having variable connections with publics but strong relationships with the Minister and Ministry. While RHAs were depicted with responsibility for decisions and actions, this responsibility was clearly to and within the specified directions and permissions of the Ministry (e.g., as established in accountability frameworks, statements from the Ministry as to minimum standards, etc.). Ministerial direction, control and sanction similarly mitigated RHA authority, answerability, and performance. The RHAs were thus primarily accountable to the Minister and Ministry, not publics and communities.

In this chapter, I explore the formal and informal roles and functions of the RHAs, and their relationships with CEOs and health regions, the Minister and Ministry, and the CANs and publics of their health regions. Although, in theory, RHAs are responsible for the oversight of the health region, it is clear that their ability to actually govern (i.e., steer, control, regulate) is in effect mitigated and constrained by many factors. These factors

include: the lines of authority between the RHAs and CEOs and the health regions and the Ministry; the volunteer nature of RHA work; asymmetrical knowledge between staff and RHA members and RHA dependence on staff for information; the “busywork” that takes place between and within their meetings; their accountability for Ministry-determined priorities; and their need to maintain cordial relations with the Ministry in order to move forward local priorities.

In examining the day-to-day practices of regionalization, it became clear that RHAs and the resulting governance model operated largely within technocratic framings of the policy innovation. Primarily, the central actors interpreted regionalization as a support to an efficient and effective health system. The practices of the RHAs were disproportionately attuned to internally focused questions and agendas of performance and policy over more externally focused agendas concerned with community engagement and public accountability.

Since regionalization and public participation policies were interpreted and practised within complex contexts, however, as would be expected, competing and overlapping interpretations and practices co-exist. Within an overarching technocratic framework, RHAs have come to occupy a dual position; although heavily weighted toward dominant<sup>31</sup> technocratic discourses that structured their day-to-day practices, actors also negotiated democratic impulses, some of which were residual elements from earlier articulations of health system governance policies, some of which were emergent

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<sup>31</sup> To review, “dominant” refers to the most effecting, determining, influencing, and hegemonic elements of a culture. “Emergent” elements are those new ideas, conceptualizations and practices (Clarke, 2007), that surface from points of, “friction, possibility, and resistance” (Brodie, 2008: 151) with the dominant, and that may reflect either new phases of, or alternatives to it (Williams, 1977). “Residual” refers to cultural elements formed in the past but that continue to have presence and influence in the present, and become threads that contemporary governing strategies, in order to be stabilized, need to “displace, incorporate, or marginalize” (Clarke, 2007: 982).

elements as new issues, priorities, and agendas surfaced. These traces and newly emerging elements are evident in democratic-technocratic accommodations, hybridizations and tensions. The meso- and micro-level practices and the dominant technocratic frameworks are detailed in Chapter 4. The democratic elements, tensions, and blending will be detailed in Chapter 5.

#### **4.1 Roles and Functions of RHAs**

Each RHA is a 12 person board comprised of community members, some of whom volunteer for the post, some of whom are identified through canvassing procedures and then asked to volunteer, all of whom are screened (Ministry 7) and ultimately appointed to the RHA by the Minister via the Lieutenant Governor (R 8.2 Regional Health Services Act, 2002). Tenure on RHAs lasts three years, although individuals can be reappointed<sup>32</sup> (R 8.2 Regional Health Services Act, 2002). The Minister also names the Chair and Vice-Chair of the boards (R 8.2 Regional Health Services Act, 2002).

As is typical with many boards, the RHA Chairs routinely serve as their board's public face (for example in media contacts or public ceremonies) (Chair 1-3, 5-8), and as the primary contact to the board for the Minister, Ministry, CEO and region staff (Chair 1-3, 5-8, 10, 11). With respect to the operations of the RHA, the Chairs work with their CEOs to set the agenda for RHA meetings and to ensure that meetings then attend to this agenda and the business of the RHA (Chair 1-11). Chairs also assume a role in ensuring that due process is followed as the RHA conducts its business, and that its work complies with governing Acts and policies (Chair 1-11).

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<sup>32</sup> As seen in Chapter 3, ten of the Chairs had served with their RHA since its inception (and thus had been reappointed), nine of whom had been involved since the introduction of the DHBs in the 1990s, with some having roots that extended to the former hospital, facility and services boards.

As written in the *Regional Health Services Act* (R 8.2, 2002), RHAs are accountable to the Minister of Health (not the publics and communities of the health region – a topic that will be returned to in this chapter) for the governance of the health region. With their health regions (comprised of the RHA and all the staff, facilities, technologies, and other resources of the health region), RHAs are responsible for the planning and delivery of health care services in their regions (although some services are delivered through provincial agencies, such as the Cancer Agency). In practice, this planning, delivery, and governance role is highly structured (and contained) through Ministry priorities, standards, and accountability requirements that formally tie the RHAs to the planning and decisions of the central administrative state (Ministry 1, 6, 8), and as will be seen (section 4.2) much of the actual work of planning and delivering is delegated to CEOs and their staff.

In addition to these broad areas of activity, the interviews described the following day-to-day RHA activities.

1. Strategic Planning: On three to five year cycles, RHAs work with health region staff to establish a strategic plan for the organization (including mission, vision, guiding values, and priorities). These plans accommodate Ministerial priorities, available resources (financial, human, infrastructure, other), and local health needs.
2. Policy Monitoring: As part of their governance duties, RHAs then use the plan to set policies and then, on regular and predetermined cycles, monitor progress, performance, and adherence to the policies.
3. Meetings: RHA members attend monthly public (i.e., open) and non-public (i.e., in-camera meetings, closed to the public) meetings, and (on an as-need basis)

special and sub-committee meetings. During meetings, members attend to the agenda (as set by Chair and CEO, as structured by larger cycles and Ministry planning and reporting requirements, and as adopted by the board at the start of each meeting).

It is the expectation that frank and open discussions will occur in non-public meetings, as will consideration of sensitive and developing issues, and issues deemed “not ready to go to public forum” (Chair 2, 11; CEO 4). Decision-making, voting, and passing of motions occurs, as required by law, in public meetings. Once decisions are made, members are to present united, publicly supporting group decisions (Chair 5).

4. Listening and Discussing: A significant portion of meeting time includes listening to presentations, discussing issues, and sharing ideas, thoughts and concerns (calling on their personal knowledge, skills and experiences, as well as information gleaned from media, publics, other boards, health system workers and stakeholders, and so forth, during their preparatory reading, self-education, conferencing, etc.). After hearing CEO and staff plans and ideas, RHA members ask questions and flag concerns, and ultimately, indicate their level of support for the plans. While consensus is hoped for, in practice, formal decisions are made via recorded vote with majority-rule.

5. Attending to Group Processes: Within meetings, members (especially the Chairs) encourage discussion; manage intra-board conflict; help build and sustain relationships within the board; prepare, participate, speak, share, ask questions, and listen respectfully to what others have to say. There is an expectation that members will declare conflicts of interest with RHA business and agenda items, and abstain from these discussions and decisions.



6. Sub-committees: Many of the RHAs use sub-committees (e.g., audit, stakeholder liaison, governance), and members participate in these, as needed and based on their interests and skills. Members also participate in various provincial committees (e.g., Saskatchewan Association of Healthcare Organizations, a provincial governance committee formed by representatives from the RHAs and the Ministry).

7. Education: RHA members engage in education and preparatory practices. These include less formal acts such as individually readying themselves for monthly meetings (reading reports prepared by other RHA members, the CEO and staff), reading related literature and reports, reading and listening to news and media reports, attending conferences, conventions, provincial education forums, and so forth. These activities help educate members about the health system, and related local, provincial, national, and international issues.

Other more formal preparation activities are provided through semi-regular orientation and education sessions conducted by: (a) the boards themselves, (b) the CEOs and health region staff, (c) the Ministry, and (d) external agencies (e.g., The Conference Board of Canada). In general, sessions offered by RHAs focus on orientating new members to roles and functions of the board, expectations of the RHA, and other details such as the history of the region. Orientation by CEOs and staff introduce the region, its facilities, staff, organizational structure and portfolios, and current, historical and potential future issues. Sessions from the Ministry focus on new programs and initiatives, accountability documents, legislation, governance expectations, and governance models and practices. Boards, health regions, and the Ministry also work with a provincial governance committee to provide annual training sessions covering functions and

limitations of governance boards, processes for CEO and RHA evaluations, reviewing financial sheets, facilitating meetings, and so forth.

No interviewee cited education or orientation practices specific to externally focused RHA roles in linking, connecting, engaging, and representing communities and publics, and several interviewees volunteered this gap as a shortcoming in board orientation, training and/or skills sets (Chair 1, 6, 7; CEO 4-7; Ministry 4, 7).

#### **4.1.1 The RHA as “Governance Board”**

When describing RHA roles, the Chairs, the CEOs, and the Ministry officials, readily and consistently (perhaps even habitually) identified the RHAs as “governance boards.” Within moments of an interviewee beginning to describe the roles and functions of the boards, they would call on this descriptor. Interviewees would then distinguish a governance board, focused on broad and strategic policies and issues, from a managerial board, focused on internal operations. These distinctions were accompanied with explicit expectations that RHAs “stay out of the weeds” (i.e., the operations) (CEO 8). A consistent theme in the interviews was the view that RHAs needed to perform their roles while being sensitive to the line between governance (an RHA’s domain) and operations (a CEO’s domain). Five Chairs spontaneously commented that their roles were restricted to the governance-level, and that this carried strict expectations that they “follow good governance practices without moving into a management role” (Chair 4), and that they “cut the line” (Chair 5) between the board and the day-to-day operations. This distinction was echoed in CEO (CEO 5-8) and Ministry interviews (Ministry 3, 5-7). There were also comments, however, noting that RHAs needed to balance this distancing and strategic governance focus to ensure that they not become token or “rubber stamp

boards” (CEO 1, 5, 6; Chair 8; Ministry 5), and to ensure that they serve as directing bodies, holding CEOs accountable for enacting board decisions. This sentiment is exemplified in the following quote: “[T]he board has to maintain a certain level of authority, that management has to look and say, ‘Yeah the board still has some control over what we do.’ ” (Chair 4) But not all of the interviewees agreed. Given the limited number of meetings, one CEO noted that “You really, honestly, cannot pretend to steer the organization [when as a board you are] meeting only 11 times a year.” (CEO 5)

It is intriguing that boards were cited, first and foremost, as “governance boards,” but that governance, in their descriptors, denoted boards that stay out of internal operations. RHAs were to be responsible for broad and strategic oversight of the health regions, yet were described with busy, full agendas, and highly-structured practices that encouraged an internal focus (e.g., cyclical planning sessions with staff, managerial oversight of the region, policy and performance monitoring of the region, board meetings and sub-committees, board evaluation, and board education activities). Actors made far fewer references to the governance roles of RHAs in terms of their responsibilities for steering and overseeing the organization and externally connecting the RHA to its stakeholders and broader communities (e.g., strategic partnerships and integration, community linkage and connection, external engagement and liaison, explicit acts of representation, etc.). Externally focused elements appeared in their practices, but sporadically (not readily and consistently) and in ways much less specific and prescribed. Governance appears to be used in their discourse to denote a board focus on policy not operations, and as a distinction between their work and that of the CEO, as opposed to a

an explicit focus on the steering and directing of the organization and a horizontal linkage of the organization with its publics and communities.

Imagine if central actors had responded with “we are a governance board, responsible for representing the interests of the communities and ensuring that corporate and business plans and decisions marry with their interests, and that the decisions and actions of the organization are known and understood by these communities.” How might day-to-day practices have then developed within this framing? As will be seen, sporadic descriptions appeared that resonated with such interpretations, but these were occasional, and not the dominant, primary, more routine or habitual reply.

#### **4.2 Roles and Functions of CEOs, Health Regions and RHAs**

While the RHAs are the governing bodies of the health region, and are technically responsible for the planning and delivering of health care services in the region, they delegate this authority, transferring particular responsibilities for planning and the actual delivery of care and services to the CEO. In this way, the day-to-day work of a health region, its planning and delivery of care and services is completed by staff of the health region, under the direction of the CEO (an RHA’s only employee) (Chair 1-8; CEO 1-8).

The CEOs, with their staff, and with the approval of the RHA (and the Ministry), then plan, organize, and deliver the services of the health region, accommodating RHA priorities and policies, and in accordance with Ministerial priorities, policies, standards, and targets (Chair 2-5; CEO 1-8). Working with a senior leadership team (and cascading from there to managers, directors and general staff), the CEOs conduct the day-to-day business of the health region. This business includes planning, prioritizing, establishing, and providing for health care services, facilities and programs, within the resources of the

region (financial and other), and within the parameters set for by the board and the Ministry (Chair 1, 5, 8, 10; CEO 1-8). This process of accommodating RHA priorities and policies and ensuring accordance with Ministerial priorities, policies, standards, and targets, significantly structures RHA and health region practices.

In addition to these activities, interviews detailed the following practices.

#### **4.2.1 CEO Oversight**

RHAs were cited with supervisory roles, wherein they would oversee the work of the CEO (and through the CEO, the work of the health region). Activities here included (a) hiring the CEO, with the approval of the Ministry (Chair 3; CEO 7; Ministry 3, 5, 6), (b) ensuring CEO performance of duties, and (c) delegating to the CEO (and by extension the CEO's senior leadership team and staff) responsibility for the day-to-day planning and delivering of services. In this way, the regions serve as the hands-on, operational ends of health care delivery; the RHAs oversee, the regions do.

As part of their oversight, RHA members would read regular reports (presented monthly, quarterly, bi-annually, etc., as per an established reporting and planning cycle (Chair 1, 7; CEO 4, 7)) prepared for them by the CEO and staff. These reports detailed the region's finances, client/patient and staff satisfaction levels, service quality, safety issues, potential risks, and program and facility utilization reports (Chair 1, 4, 6, 7, 19; CEO 4, 5, 7, 8). These reports were written by the CEO and staff for RHA members to help them monitor policy adherence, ascertain progress and performance of the region, ensure sustainable resource allocations and the delivery of necessary health care services, and as a means of briefing and preparing RHAs for deliberations and discussions. Through these practices and the reports, activities can be seen to emerge that structure

RHA roles and further guide their focus toward internal concerns of system performance (as opposed to more externally focused concerns of public accountability, civic engagement, community empowerment, etc.).

Interviewees described a significant amount of CEO work with the board, sharing information with and educating the board as to issues, operational strategies, programs and services. This information briefing ensured that RHAs were (a) apprised as to progress and performance in regards to policy and priorities (e.g., efficacy of local health human resources recruitment efforts); (b) had the information they needed to oversee the region's work and make the decisions the CEO and staff were bringing to them for discussion, input and, in some cases, approval; (c) up-to-date on potential or developing issues (e.g., community sensitivities to a possible service closure); and (d) had the information needed to respond to potential public questioning they may encounter as board members out in the community.

While in theory RHAs served an oversight role, as the above practices show and as some interviewees explicitly noted, in practice, RHA members often formed opinions and made decisions using data gathered and interpreted for them by the CEO. In this way, CEOs educate and guide RHAs as much as RHAs oversee CEOs. The following quotes each show the dependence of RHA on CEOs, a dependence that undoubtedly mitigates an RHA's ability to truly steer and influence (i.e., govern) the CEO and region.

It takes a long time for [RHA members] to understand the topics, the issues behind the issues .... So, when it comes to policy development or strategic planning ... we have to ... and typically what has happened then, we feed them. (CEO 5)<sup>33</sup>

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<sup>33</sup> When using quotes, my practice is to cite the quotes verbatim, eliminating speech fillers (e.g., ums and ahs), stutters, and stammers. Ellipses indicate that words were removed from the quote, to shorten it and maintain the focus on the key point being discussed. Quoted text that appears in italics denotes words

We're fed; we're led and fed as a board, because we don't ... we are not in the centre .... I think we rely on staff more than anything .... a lot, most really, of our ... information comes from the senior team. (Chair 1)

And let's face it: if we [the CEO and staff] know that X is just not going to go through, than it doesn't get put forward. You know the CEO [has] got to have some smarts. And part of it too, is that a good CEO would prepare the board, "We are going to need three meetings to discuss this before we actually give them the question." So, we better have the presentations ready and educate them on this topic and then we'll proceed. (CEO 6)

This last quote shows the dependence of an RHA on the CEO and opens the door to active and intentional steering of the board by the CEO, creating a path for CEOs to exercise power, steering and managing RHAs (not just being guided by them).

While, in theory, RHAs were to oversee the work of the CEO and region, in practice, as demonstrated above, RHAs relied on the CEO and staff for much of the very information they would then use to monitor and evaluate performance, consider issues, approve plans, and in general, execute their duties. This system of relations contributes to a closed, interdependent, and insular system, and these practices undoubtedly mitigate an RHA's ability to truly and independently oversee and guide the activities of the region.

As seen in the following quote, depending on the CEO, the dependence of an RHA on the CEO for information could significantly constrain their authority and power.

One of the things that we had talked about was boards who were captives of their CEOs. And [name] stood up and said "do you guys know that you are the captives of your CEO? How do you know that your CEO isn't manipulating you and running you down his or her particular agenda?" And [name] just confronted [the RHA] with that .... and there were some big [CEOs] who could really be influential. (Ministry 7)

The potential of a CEO to hold an RHA "captive" indicates a role tension, rooted in part in the competencies that RHA members bring to the governance table, and in part

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spoken by the interviewer not the interviewee. In limited instances, quotes have had minor corrections (e.g., grammar) to aid comprehension and, given their presentation in an academic setting, to help ensure respect for the speaker. In no cases do these corrections change the point or focus of the quote.

in the accountability frameworks and agendas set by the Ministry and that dictate RHA meetings, work cycles, and meso- and micro-level practices. A disjuncture exists between, on the one hand, who the boards are, the competencies they represent, the skill sets they bring to the table and, on the other hand, the activities that they are to oversee. This disjuncture fosters a reliance on the CEO for data, briefings, and informing, and creates an avenue through which RHA power is limited within this governance model. I will return to this topic in the next chapter (see section 5.3 and 5.4), when discussing competing expectations for and visions of the knowledge, skills and competencies of RHA members.

#### **4.2.2 Resource to the CEO**

In addition to serving CEO oversight roles, RHAs were described as resources to CEOs. This resource role was described in three major ways. First, RHAs served as “a sounding board” (CEO 3) for their CEOs, hearing CEO ideas, and serving as a group on whom the CEO could “bounce off ideas” (Chair 8) and “fly trial balloons” (Chair 11). Within this role, RHAs would hear CEO ideas and plans and then offer their opinions, indicating their support for, and concerns with, the ideas brought forward. RHA practices within this also included working to influence the CEO and the decision-making of the CEO and senior leadership team, maintaining authority and holding the CEO accountable to and for enacting board decisions and priorities.

Second, RHAs served as public sensors for CEOs; an alert, apprising CEOs as to developing public and community reactions and tensions. Within this set of practices, RHA members would notify the CEO, making him/her aware of community issues and information that would come to the attention of RHA members from communities,



publics, and stakeholders, helping CEOs (and by extension health regions) be aware of developing issues and tensions. This function is demonstrated with the following quotes.

Also, one of the last items on that in-camera meeting is: “board members, have you been hearing something we need, the rest of us need to know about, or the CEO needs to know?” (Chair 3)

If [the information received in a community interaction] is something that the CEO needs to know about then you would take it to him. (Chair 7)

Sometimes it is just something I pass on to [the CEO]. Sometimes it is just for their knowledge. (Chair 6)

Third, RHAs served as public voice to CEOs, bringing knowledge of who the region served to the planning and decision-making table, ensuring that decisions were considered and vetted through the lives of communities and publics (i.e., boards serving as a voice for the community). Since CEOs, in their professional role, have more distanced relationships to communities and publics, they recognized the importance of getting such information from the RHAs.

They do bring with them ... a broad community perspective ... the issues, the needs, the concerns of their communities and they bring those to the table in a way that we, as a management team, probably can't or not as richly as [RHA members] can ... (CEO 2)

Depending on the intentions for such information sharing, this sensor role resonates with both technocratic logics (e.g., sensing to adjust public messaging in order to encourage public support) and democratic logics (e.g., sensing to adjust system planning and action in order to reflect public concerns) and will be discussed in section 5.2.1 of the next chapter.

### **4.3 Roles and Functions of the Minister, Ministry and RHAs**

The Minister of Health would typically serve as the political face for the health care system. This role would entail representing its case to Executive government and the

government in general (for example in budget planning processes) and answering for its performance and other issues raised in the legislature and other public venues (e.g., community events, media, political campaigns and elections, etc.) (Ministry 1-3, 6).

As a Ministry, public servants assist the government by strategizing and planning for the health care system of the province, identifying priority action areas, and setting policies, standards, and targets to guide the work of the various players (such as RHAs) (Ministry 3-5). The Ministry was cited as the primary funding agency for health care services, allocating funds to various players (e.g., RHAs and the Saskatchewan Cancer Agency, fee-for-service medical service providers, etc.) (Ministry 1-8). The Ministry also decided RHA membership and played an active role in supporting, orientating, and training members to their role and function (Ministry 4-7).

Within this domain, RHA practices in relation to the Minister and Ministry included: enacting Ministry-determined priorities; keeping the Ministry informed about local issues; maintaining cordial relations with the Ministry in order to accomplish the goals of the RHAs; and accountability for the health regions' performance. These practices are discussed in more detail in the next section.

#### **4.3.1 Locally Enacting Ministry Determined Priorities**

The interviewees consistently indicated Ministerial responsibility for setting the broad health vision and priorities for the system that then guided the work of the Province and the regions. RHAs and regions enacted decisions and performed their roles in accordance with this vision and these priorities (Chairs 3, 6-8, 11; CEO 2-4, 6, 7; Ministry1, 3, 5-7). The Ministry was ascribed ultimate responsibility for health care and system decisions for then directing, guiding, supervising, and liaising, and

communicating with RHAs and regions, keeping them informed of these plans and directions. The Ministry's pivotal role in the decision-making process reveals another layer of complexity to already complicated lines of authority. With the Ministry deciding, CEOs doing, and RHAs overseeing, it became evident that this division of labour further constrains the power and authority of the governance board. With the following comment, significant power is seen to lie with the political-administrative state.

I think the Ministry and the Minister still like to control what's happening. ... So, we're still pretty controlled by the Department in a lot of ways. ... You know, the Minister will often [speak of], and physicians will often say all this power and control that the [RHA] has, but yet, you know, we're governed by the Accountability Documents. We have lots of rules and regulations that we have to follow. So, people seem to think that we have a lot of authority but as Authority members we don't feel that we have an awful lot of authority. (Chair 1)

The Ministerial plans and priorities that RHAs were to enact were conveyed to RHAs in multiple ways including: (a) annual accountability documents issued by the Ministry, detailing key actions the RHAs would be required to report on throughout the upcoming fiscal quarters and year; (b) reviews and approval of RHA operational and strategic plans, including budgets and checking with the Ministry for approval of any significant changes or decisions (Chair 3-5); and (c) ongoing ministerial interactions and correspondence, and at regularly scheduled meetings such as the Minister's Forum (a semi-regular meeting between RHA Chairs and the Minister, accompanied by various senior leaders from the Ministry) and Leadership Council (a semi-regular meeting between CEOs and the Deputy Minister and senior leaders from the Ministry).

In these ways, through this very structure, it is possible for the central-administrative state to exert significant control and influence over the local practices of health regions. While other research (e.g., Kouri, et al., 2002; Lewis et al., 2001; Neville

et al., 2005) reported accountability and authority tensions amongst the actor groups studied here, no comments were made in the present interviews that noted the very limiting effect of this structure on the governance role or public accountability roles of the RHA. One CEO did refer to the Ministry as “big brother” (CEO 8), but aside from this comment, the interviews revealed no overt rejection of this structuring and perhaps even acceptance of these lines of authority.

You can't do anything [like close a facility] unless you take it to the Minister because it embarrasses him. And so we have a procedure. We do. We go to the Deputy first, and we tell him, you know, “this is what we're discussing, and do you think there is a possibility we can do it?” And he'll say, “yes” or “no, there is no possibility,” or “we had better discuss it with the Minister first.” (Chair 5)

At the end of the day, all roads lead to the Minister. The Minister is ultimately responsible, and through the Minister, the Cabinet and Premier. And as such, governments from time to time, for political or economic reasons, will interfere, not interfere that is incorrect, will intervene in the operations or direction and strategic direction of an RHA, and I think, in their minds, it is with good reason, because they are responsible. (Min 1)

These observations indicate that there is a clear chain of command—“procedures”—in the determination of major decisions (like closing a facility). Ultimately, the Minister of Health is responsible for the activities of the RHAs, but this office is also shaped by the goals, responsibilities, and priorities of the Premier and Cabinet. As is also apparent, the Minister's decisions are shaped by many economic and political factors. As a result, major decision are vetted before they become “embarrassing” to the Minister, but if the government does not agree with the direction of an RHA, it will “interfere” or “intervene” in its operations, demonstrating its governance capacity to steer and direct.

#### **4.3.2 Keeping the Ministry Informed**

In addition to enacting Ministry priorities, RHAs also play a significant role in keeping the Minister and Ministry informed as to local issues. A significant part of the

agenda for meetings between the RHAs and the Minister and Ministry (e.g., Minister's Forum or with regular Ministry attendance at monthly RHA meetings), was the sharing of regional information, apprising the Minister of ongoing issues and situations, and informing him/her about what RHA members were hearing out in communities and from publics. This sharing was done to help "make them [the Minister and Ministry] better governors" (Chair 1), and as we see in the following quote, could serve to mitigate public complaints through the perception of a local connection to the Minister.

Now the advantage of this [Minister's Forum] was that in dealing with the public ... if people complained to a board chair or [RHA] member, the Chair could say, "well I just saw the Minister last week and we talked about this" or "No I haven't heard about this but I'll see [the Minister] in two weeks." And so, what all of a sudden happened, was that there was a perception issue that the Minister was far away, and well, that changed quite dramatically [with the Minister's Forum]. And it was a major commitment on a lot of people who became a part of this but we became very good friends in a lot of ways, but also the department, [we would] get an early warning on just about any problem there was. (Ministry 2)

Through the Minister's Forum, RHAs thus played a role in alerting the Ministry (Chair 1, 3, 4, 5, 6, 7, 8) as to regional priorities and developing issues to aid the Ministry in its work (Chair 1, 4, 5). The RHAs helped bridge the social distance between the Minister, who "was far away," while at the same time, the Minister's Forum provides a site for the development of social connections between board members and the Minister. Not only did the RHAs provide information to the Minister and Ministry officials, but in some cases, Ministry officials contacted RHA members as a local and current information source during the management of a politically sensitive issue.

Uh, I mean [Ministry of Health officials] will say "what do you hear out there?" You know, "what are you hearing out there?" Um, you know, with the big uproar in [community A] over the last little while ... [Ministry of Health officials] relied very heavily on, on what was happening in the community. And even though in a small, relatively small community like that, your administration out in [community A] can give you an idea of

what's going on in the community, my ties with, and my relationship with the Mayor and people on Council and, and just the people I meet on a day-to-day basis, helped the health region form opinions of what needed to be done and when and how fast. And, you know, I had government officials phoning me and saying “what are you hearing out there? What's happening out there?” (Chair 1)

In the case of a “big uproar” which can signal a legitimation crisis for the government, it is clear the Ministry is anxious to understand local concerns and defuse conflict.

Moreover, the quality and credibility of that information is structured, in part at least, by the social capital of the Chair. In this case, the Chair’s connections with local elites--“the Mayor” and Council -- would provide particular kinds of information to the Ministry (as opposed to other kinds of information from marginalized groups). At the same time, the Chair’s positive relationship with the Ministry represents a form of social capital that can be used to convey Ministry concerns and wishes to local elites.

The above descriptions convey supportive roles between the RHAs and the Minister and Ministry, which could read as the RHAs dependency on government officials. However, this relationship was mitigated by other comments that indicate that some chairs saw their roles as representing the voice of the regions constituents. In particular, some chairs described their role as “serving as a voice of the public to the Minister” (Chair 1), representing their region (its issues, needs and concerns) to the Province, “speaking up for the residents of our Authority” (Chair 8), and “trying to influence the Ministry” (Chair 2).

In this way, paralleling relationships between RHAs and CEOs, a dual-focus exists to the RHA role, wherein boards served both (a) the system (as represented by the Ministry), whom they are helping to inform, and make better governors, and (b) the lifeworlds, communities and publics that comprise the region, and on whose behalf they

speak to the Ministry, trying to influence the system and have it better reflect their concerns and issues. The duality of the RHA role appeared throughout the interviews and will be discussed in the next chapter. At this point, note that as with RHA roles in sensing and voicing lifeworld information to CEOs and health regions, this role of informant to the Minister and Ministry resonates with both technocratic and democratic logics.

Depending on both the intention of the sharing and the system reaction to the information it may be imbued with technocratic logics (e.g., adjusting public messaging to manipulate public support) and democratic logics (e.g., adjusting system conceptualizations and planning to better reflect and accommodate lifeworld concerns).

### **4.3.3 Relationship Maintenance**

Since RHAs were constrained by the priorities and accountability measures of the Ministry, they worked to maintain productive relationships with the Ministry.

Interviewees commented that RHAs needed to understand the way the Ministry worked and to try and influence them within that, by “getting your points across ... but ... in non-irritating ways” (Chair 5); working with the Ministry, not “locking horns” (Chair 3); following “unwritten rules” (Chair 3); maintaining positive relations (Chair 5, CEO 2); ensuring “no surprises” (CEO 6; Ministry 2) and that the Minister was never embarrassed (Chair 3); and, explaining to the Minister local needs and situations, while accepting that “the Ministry has ultimate authority over the board” (Chair 4). In effect, RHAs need to find ways to get along with Ministry officials in order to accomplish the RHA goals while meeting the Ministry’s expectations. When there was conflict, the Ministry severed the lines of communication with the RHAs as the following case demonstrates.

You have to come up with some way of getting along in a reasonable manner with the bureaucratic system in the Department of Health, and the

Minister. You have to be able to get your points across, but you have to be able to do it in a way that doesn't irritate the hell out of somebody. If you irritate them, I had this problem, we had a different Chair and a different CEO at one time, and the Department of Health and the Minister didn't even want to talk to us. There was no rapport. (Chair 5)

The ability of the Ministry to cut off communication and the need for the RHA to not "irritate" demonstrates that the balance of power tilts to the political-administrative state. As a result, and not surprisingly, few RHAs are willing to stand up and challenge government positions, an action this CEO yearns for.

I think I would like ... a group that would on occasion stand up to the Minister and Ministry. ... I'm not seeing in administrative leadership across the province or the boards, a willingness to take on government. I don't think you have to necessarily be adversarial all the time, but I think the Ministry and the Government need to have RHAs that say: "No Minister, you need to go back and rethink that; for these 10 reasons that's not good for our region." ... I haven't seen that a whole lot. (CEO 6)

Since the RHAs exist in a hierarchical relationship to the Minister and Ministry in which the latter steers and guides (i.e., governs) the activities of the RHAs, the RHAs must maintain cordial relations with government officials in to achieve RHA goals. As a result, RHAs can be constrained by what they can and cannot say to the Minister and Ministry.

#### **4.3.4 Accountability to the Ministry**

As per official accountability agreements drawn up by the Ministry and the legislation forming and enacting the RHAs, the Ministry assigns responsibility for health region performance to the RHAs (as opposed to the CEO or health region staff). As part of this responsibility, RHAs are required to report regularly to the Minister as to the region's performance, flagging any ongoing or developing issues that may be affecting the region (e.g., health care provider shortages, fiscal limitations and strains, service delivery issues, community concerns and tensions, etc.). RHAs are also required to secure Ministry approval of major decisions before announcing or enacting them (Chair 1, 5;



Ministry 6). Ultimately then, any significant changes that may be proposed by RHAs and their regions must be reviewed and approved by the Ministry. In this way, the Ministry structures and controls a substantive portion of RHA work. In short, the Ministry decides, the CEOs and health regions do, and the RHAs oversee. Relationship, responsibility, authority, answerability, performance, and sanction, key elements to accountability (Fooks & Maslove, 2004), are clearly accountability elements in play between the RHA and the Ministry (not the RHA and local publics and communities).

As noted earlier in this chapter, RHAs were consistently described as governance boards. Commonly added to this descriptor, was the notion that they were governance boards formally accountable to the Ministry. Note with the first quote below that ultimate reporting is to the Ministry and ultimate authority rests with the Ministry.

The board ultimately reports to the Ministry of Health... We have to follow the guidelines set by the Ministry; they tell us, we present a budget, they approve the budget, we are expected to then run with, and the directive has been to run a balanced budget and to keep them apprised of any issues that may require them to become involved. ... The Ministry has ultimate authority over the board. (Chair 4)

There's a lot of regulation out of the Ministry, a lot of accountability. Certainly, they have to make sure that, you know, that they are providing that accountability, making sure that the accountability is going to the Ministry. (CEO 4)

This accountability tie was accomplished formally (through accountability documents, legislation, and official reporting relationships), and, as can be seen in the next quote, informally (e.g., via interpersonal relationships and informal or "unwritten rules").

There's been, you know, I guess, unwritten rules out there that you don't do those kind of things. ... You know we just sort of, well there's ... that unwritten rule that says "we will work together" and "there needs to be an understanding." The Minister needs to be, you know, because he, ultimately that's where the buck stops, you know. If something happens, I'm sure they can go after the regional health authority and we can do all

the work we want, but you know, it ends up in the Legislature and the Minister has to account for it. (Chair 3)

These formal and informal accountability lines tethering RHAs to the Ministry are in contrast to ties connecting RHAs to other bodies, such as communities and publics. In effect, these lines convert the boards from governors operating on behalf of the public to administrators operating on behalf of the central-administrative state. What flows from this accountability are practices heavily attuned to micro- and meso-policy issues and tasks, and activities of performance monitoring (i.e., internal gazes), as opposed to community linkage, representation, advocacy, and so forth (i.e., external gazes). This accountability tie is a direct inversion of the ties called on with the 1992 announcements, calls heavily steeped in democratic and population health logics, and calling on community control and public accountability.

Although formal accountabilities tied RHAs to the Ministry, three Chairs cited informal accountabilities tying them to local communities and publics. This finding parallels that of Lomas et al. (1997b) who noted structural ties aligning boards with Ministries, and board opinions aligning them to local communities. This competing interpretation of the role carries democratic traces and will be discussed in Chapter 5 (see Section 5.3.1).

#### **4.4 CANs, Communities, Publics, and RHAs**

The RHAs serve as an important interface between the publics and communities and the Minister and Ministry. But in the recognition that the RHAs, and de facto the government, needed other mechanisms to engage a wider range of public opinion, the Regional Health Services Act (R 8.2, 2002) provided for the establishment of the Community Advisory Networks (CANs). These bodies would serve as formal avenues of

communication between RHAs and health regions and the communities and publics that comprise the region. The CAN's stated role was to advise the RHA in its planning and decision-making in regards to health services for the region (R 8.2 Regional Health Services Act, 2002; Saskatchewan Health, 2001). In practice, and at the time of these interviews, not all regions had established CANs.<sup>34</sup>

In addition to relating to their RHAs and health region through formal vehicles (such as a CAN), communities and publics are also, in theory, able to engage in less formal ways (e.g., conversations at community events, letters and calls to members, visits to CEOs, etc.). RHA practices in relation to CANs and in relation to communities and publics in general were described in the interviews and will be detailed here.

#### **4.4.1 CANs: A Formal Site of System-Lifeworlds Interface**

CANs were introduced as a new actor group within the 2001 governance model. While CANs appeared in the announcements and literatures detailing amendments to the 1992 model, explicit detail as to their structure and role was not provided. Interviewees commented that roles for CANs were not clear, nor was the distinction between CANs and RHAs. RHA roles then included defining and operationalizing the new structure (i.e., decide who, what, where, when and why for their local CANs) (Chair 1, 3-9, 11, CEO 1, 2, 4, 6, Ministry 4, 5), and delineating CAN functions to ensure that CANs did not assume RHA roles. As an example:

The first issue you had to deal with when you look at the CANs, I should add, is: you did not, as a board, want the CANs to become in their minds, a quasi-board. (Chair 4)

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<sup>34</sup> Of the 11 RHAs interviewed, less than half reported having established CANs, and only one indicated satisfaction with the function of its CANs. The remaining sites reported struggles to defining clear and meaningful roles for this body.

Interviewees frequently suggested that RHAs had to work diligently to ensure CANs understood that they were an *advisory* network, with input into (but not decision-making power over) the decisions of the RHA; RHAs would listen to their input, but not necessarily act on it (Chair 3, 4, 8, 9, 10, 26, CEO 4, 5, 7; Ministry 1-5; CANs 4, 5).

And this was an issue that was agonized over by all the boards that we talked to, is: how you set them up without them wanting to have this control? (Chair 4)

Basically, the word advisory is exactly that, it advises the board ... you give advice, it doesn't mean it is taken. (laughs) (CAN 5)

As seen from the following quote, this limited role was frustrating for one member.

I've served on advisory committees and they are only as effective as the group above you, in this instance, the RHA ... [and] the moment you start expressing ideas on policies and so forth then [RHAs] quickly back off and say "that's not what we want to hear. We're in charge here." (CAN 4)

Once roles (however contested they may be) were articulated and CANs were introduced, specific practices included: (a) attending formal and organized meetings (called by RHA) (CANs 1-5); (b) reading information packages in preparation for meetings (CANs 1-4); (c) talking and sharing input and ideas amongst other CAN members and with RHA and region representatives (CANs 1-5); (d) responding to RHA and staff solicitations for CAN feedback (as to, for example, strategic plan drafts, new facility working plans, posters and flyers, etc.) (CANs 1, 3, 4); (e) helping provide RHAs and health region staff with relevant local history and knowledge (CANs 3, 4); (f) helping RHAs and health region staff understand community issues (CANs 3, 5); and (g) helping the RHA and region talk to publics about these issues (CANs 1-4).

#### **4.4.1.1 Informing the Public via CANs: Information Travels Out**

CANs were described as routes for the system and RHA to inform the public. RHAs were to be responsive to CANs (CANs 3, 4), finding answers for CAN generated

questions and reporting this information to them at future meetings with the necessary data (CANs 2-5). CAN members were then expected to share the information with their community and public contacts (CANs 2-5).

CAN members brought concerns to the meeting; these were addressed and explained by staff and members were able to go back into the community and bring that knowledge out. “This is what’s happening.” (CAN 3)

Some of this information-sharing between CANs and communities was done for informing purposes and some, as is seen in the next quote, was done strategically, in an effort to help RHAs and regions quell rumours and allay concerns.

You could hear somebody at coffee row, say that “the chairperson of the [RHA name], gets paid \$100,000 per year.” He doesn’t, you know. You look on the Internet and its maybe \$25,000 or something like that. So if we CAN members had some kind of factual knowledge, something like that, we can dispel untruths and rumors. (CAN 2)

Similarly system-focused roles appeared within descriptions of CANs, such as the following example where CANs were expected to help “sell” ideas to communities.

[CANs] can be used to take information back to the community. That’s one of their key roles. If you can get the CAN convinced, you know, buying into what you’re doing, then they can take it back and begin to sell it in their community. They can have a huge, huge impact. (Chair 3)

#### **4.4.1.2 Informing the System via CANs: Information Travels In**

CANs were described as routes for publics and communities to inform and influence the system. Thus, in addition to serving as a conduit for system informing of publics, CANs were routes through which lifeworlds could inform the system. Through CANs, RHAs would receive feedback, hear suggestions, and maintain contact with communities. CANs were seen to serve as additional connections with community and added routes for input and engagement. And CANs, when they exist (recall that not all regions have them and that there is confusion as to their role) and are functional, can

extend the interface between lifeworlds and system. In this way, CANs can be seen to operate in part within democratic logics protecting local voice and involvement, and helping the system build trust with communities.

We need to hear that and they need to have the opportunity to tell us that in a non-confrontational setting, because it shows that we care ... and gives them an opportunity to have voice. (Chair 1).

Community connections with CANs fostered both proactive and reactive practices. Proactive practices included sharing the strategic plan with CANs and getting their reactions, involving CANs in discussions as to long-term planning and issues, and hearing from CAN members to better understand community expectations. Reactive practices included working with CANs after a situation developed or a decision was made to help CANs understand and come to support it, and then having CANs relay this information and support back to their broader communities, as in the following case.

A good example is when [facility X] changed their food preparation ... and this brought concerns that this meant ... contracting out. That was not exactly the case. What was happening was that the old kitchen and laundry were inefficient. They built this new building [with] new kitchens and laundry, and now much of the local food and laundry are done [there]. It is not contracted out to some strange, anonymous company. ... We CAN members brought those concerns to the meeting. They were addressed and explained and we were then able to go back to the community and bring that knowledge out. "This is what's happening." (CAN 3)

Thus, in addition to providing a route *in* to the system for community information (i.e., CANs ferrying lifeworlds' information to the system), CANs helped RHAs and regions by relaying information *out* to the communities and publics of the region (i.e., ferrying system information to lifeworlds). CANs were engaged in transferring health region and health system information to communities (Chair 4, 6), helping to correct false information that was in circulation in communities (Chair 7; CAN 2), and, as referenced in the next quote, serving as "ambassadors for the region" (Chair 8).

We like to use them as ambassadors in the community. These are people who know a little more than John so-and-so, that fellow at coffee row. And we find these people usually tend to be outgoing people and they tend to work effectively at that role. (Chair 8)

Once again, these practices demonstrated a dual nature to public and community roles on RHAs and now CANs. Community members were positioned within both technocratic framings (e.g., serving the interests of the system, ferrying its information to lifeworlds to try to influence and shape them) and democratic framings (e.g., serving interests of lifeworlds, ferrying its information to the system to try to effect it).

#### **4.4.2 Other System–Lifeworlds Site of Interface**

In addition to connecting with and relating to communities and publics through the CANs, RHAs were also cited with roles and practices relating them to publics and communities in general (i.e., not just those accessed through formal CANs). These practices ranged from formal and more planned connections with publics and communities to casual, informal, unplanned, random connections.

##### **4.4.2.1 Formal Connections Between RHAs and Publics**

RHAs formally connected with publics via the open portions of their regular monthly meetings.<sup>35</sup> Boards divided their monthly meetings to two parts -- open and closed. The open portion, theoretically, was open to all the public and was where RHA decisions were formally passed. However, interviewees consistently noted that public meetings were under-attended by publics, unless a significant issue (e.g., a facility closure) was being considered (Chair 1, 6, 7, 11; CEO 1, 4-7). It needs to be stated that public attendance at select portions of RHA meetings is useful. However, limiting public observation to select conversations and agenda items is not likely to encourage true

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<sup>35</sup> In December 2010, many boards reduced their meetings from 10 or 11 a year to 8, in an effort to reduce costs (Scissons, 2010b).

public accountability, the kind that could result from open meetings that allow outside public observers to see and come to understand how the board conducts its business and demonstrates accountability to its publics.

RHAs also participated in regular meetings with representatives of groups and organizations with an interest in the health region and the decisions being made (e.g., schools, tribal councils, community groups, etc.). Many CEOs and Chairs reported having developed annual “stakeholder” meeting and consultation plans. These plans outlined to whom the RHA should they talk (including how frequently and when) and from this, local representatives and stakeholders were then invited to meet one-on-one with the RHA, and attend monthly public RHA meetings. As heard in the following quote, this public engagement can be constructed to be very structured and planned.

We have a grid who we meet with. ... We meet with [a neighboring RHA] on a quarterly basis. We meet with the Ministry. We established a plan, and its kind of like the Board plan, its what we've done and its worked well, so we'll do it again, you know, kind of just a grid....who else is on there?...Um, it's an 8 x 11 sheet (laughs). (Chair 1)

These meetings helped keep publics, as represented by these stakeholder groups, abreast of what is happening, ideally bringing them onside with the RHA's position, or at least increasing understanding of its positions and decisions (Chair 1-3, 6-9, 11).

RHAs connected with communities and publics to collect information that would then educate the system as to lifeworlds. In this facet of the role, RHA (and CANs) were listening to, and gaining appreciation and understanding of community issues, concerns, and experiences. This understanding could then help RHAs members form opinions and ideas that could then be expressed to the RHA, the CEO and health region, and the Minister and Ministry during deliberations and decision-making. The following quote



demonstrates this role, where communities are approached as partners who can help improve a system plan (as opposed to as audiences to be sold on a plan).

[RHAs need] the ability to emphasize with people, to know and understand what they're going through when a program changes in their community, and to not just callously go in and make the change, and say "this is good for you." But to understand that [change] from their perspective, and yet be firm enough that you have to make the tough decision. And I think that when people are given a chance, an opportunity to listen, to hear what your plan is, and where [the RHA] would like to take [a service], and then have some input into [that plan], and [for planners to] not be so rigid, you know, I've learned that every plan can be improved upon. Everything that we do can be changed for the benefit of the general public. (Chair 3)

Later, this same interviewee cited a specific case that demonstrated a situation in which health region staff had developed, and the RHA had approved a plan to accommodate a facility renovation. As the Chair states, the original plan was developed internally, and considered and accommodated the system and staff. When this plan was taken to the public, it was pointed out that plan failed to consider adequately and accommodate lifeworld concerns of patients, residents, and families.

We may have preconceived ideas and then we get the public involved, and [those ideas] may change! ... With a good rationale ... you do things different from what you planned. [As an example] ... we were renovating a facility, and ... staff had come up with a plan to accommodate residents [during the renovations]--they were going to move them around the district. And [we had a public meeting and] the public said "No! We don't want this. I don't want my grandmother moved to [community B], or my mother to [community C]. We have a hospital with empty rooms that could accommodate people." [The public] were able to make a convincing argument and we changed our mind ... And you know ... it was the right way to make the decision .... [Community members] were able to have input. They suggested that we take another look at and we came up with a different plan. We accommodated people and kept them in the community. ... I guess maybe we had never considered [their experience]... I think we looked at what is the easiest way, and it would have been easier ... to move them. It put a tremendous strain on staff, keeping [the residents] there. ... It would have been much easier to disperse residents throughout the region. We had empty beds all over. And by doing this, by keeping

them here, we had to go back into the old hospital, and get those rooms ready for occupancy and do many things. (Chair 3)

In this case, the technocratic logic (the RHA's "preconceived plan") was at odds with a lifeworld view of the social and emotional impact of moving individuals to another community. Thus, these structured and formal connections between RHAs and lifeworlds provided a site for publics and communities to influence the RHA and the system.

#### **4.4.2.2 Informal Connections Between RHAs and Publics**

RHAs also connected with publics and communities in informal and less structured ways. RHA members would serve as the RHA and health region face to publics (Chair 2, 6, 7; CEO 6). They would attend community events and openings, community gatherings and, in general, be present in their communities as they went about their daily, personal and professional, public lives (e.g., at the grocery store, ballgame, church, in phone calls to their homes) (Chair 1, 3, 6, 7, 10, 11).

People in the community, they soon learn, they know who is connected to the Health Board and they are not hesitant to call. They know our phone numbers. They will stop you on the street or they will chat or you'll come in contact with people sort of wherever you are, whether it is in the lineup at the grocery store or whether you are watching a hockey game or a walk in the park or wherever. (Chair 6)

Rural boards practices included attending "coffee row" (Chair 5; CEO 4), and there answering questions from publics, checking in with them, sharing information with them, and gauging local mood. While in these public spaces, RHAs members were expected to facilitate change; manage rumours and counter negativity that they might hear when out in the public (Chair 3; CEO 4), and work where they could to get public and community leaders to understand and appreciate health system issues and decisions that had been made. When necessary and useful, RHA members were to explain that

board decisions were made by “people like you” (Chair 1 and 3); increasing the credibility of the region and its decisions and helping to counter cynicism.

While most of this public connection was done in the open, as is demonstrated in the following quotes, RHA members also practised unannounced listening.

And sometimes too it is just, it’s like eavesdropping. I mean you hear people talking about something and they don’t have a clue that you are connected but it’s what you pick up. (Chair 6)

They also have good antennas out in the communities, so if they pick up that there are things that are going well, they’ll let us know. If they pick up that there are things that aren’t, they’ll certainly let us know or they’ll give me a heads up. So in some ways they’re, well I use the term spies, but they are the ears of the RHA that’s out there. (CEO 6)

All of this connection with community, whether formal (via CANs or regularly scheduled stakeholder meetings) or casual (e.g., at the grocery store or on coffee-row), overt or covert, was an expected practice for RHAs members. This issue of covert engagement will be discussed again in section 5.2.2 in the next chapter.

#### **4.5 A Cohesive and Mundane Narrative of Day-to-Day Practices**

The interviews provided a rich and detailed description of the contemporary practices of RHAs, including meso- and micro-level information of the daily, monthly, and annual processes and practices of the boards themselves, and the boards in relation to CEOs and regions, the Minister and Ministry, and CANs, communities, and publics of their regions. In particular, the RHAs served as interfaces between the system and the publics and communities of the region, ferrying information back and forth between lifeworlds and the system. At times, they extended the reach of the system, at other times the reach of lifeworlds. This dual nature to their role will be discussed in the next chapter.

Substantial portions of the roles and functions were agreed upon across the actor groups and while perhaps differing in specific language or examples, they appeared

largely uncontested. The marked similarity in the understandings and descriptions of the roles, functions, and practices was striking, and through it, a cohesive, dominant interpretive framework emerged, although some contestation of CAN roles did appear. The result is a repeated description wherein the Ministry decides, the CEOs and health regions do, the RHAs, accountable to the Ministry, oversee. On occasion, CANs provide non-binding input into this process.

This cohesion varies from those findings cited in the literature review (Gray et al., 2008; Kouri et al., 2002; Lewis et al., 2001; Neville et al., 2005) that noted role contestation and clarity issues between the roles of the health regions (including the boards) and the Ministry. It is unclear whether the narrative in these interviews resulted from: (a) evolution and maturation over time (i.e., interviewees have been constructing and practising their roles long enough that they are used to the ambiguity and no longer report tensions or have developed interpretations and practices that have reduced the ambiguity), (b) selection bias in the sample (i.e., frustrated individuals might be less likely to serve as a Chair or CEO), (c) the nature of the interview (people might be less likely to report their frustrations and confusion in a face-to-face interview as compared to an anonymous mail survey, specifically asking them to rate issues such as role clarity), or (d) some other cause or clustering of causes.

Although there was general consensus about the roles, functions, and practices among the central actors, there were four exceptions to this finding. Chair 3 and CEO 8, expressed frustration with the Ministry which they perceived as keeping a tight reign on the regions; CAN 4 expressed frustration with a CAN role limited to the provision of non-binding input; and CEO 6 yearned for his/her RHA to more assert itself more

strongly to the Ministry, pushing harder for its needs and interests, rather than simply capitulating to Ministry plans and desires.

In addition to the markedly similar descriptions of practices, the interviews were also striking in their matter-of-fact, mundane, and dispassionate listing of the meso- and micro-level practices. This mundane nature was heard largely through tone, but also through the specific words and detail the interviewees shared. Through this listing and describing, highly detailed, highly structured sets of RHA practices attending to governance, CEO oversight, and Ministry and public liaison and interfacing were revealed. These listings were laden with specific and detailed tasks and duties, the result of which described a group of governors busy in their work of reading, reviewing, discussing, considering, liaising, and linking, all within their role of serving as a governance board (a term consistently used to distinguish their role from a hands-on, operations-focused board). In this way, RHAs appeared busy and engaged in many time-consuming practices. To some extent, the practices (or at least the dialogues around the practices) appeared to have become formal, routine, ritual, bureaucratic, and heavily attuned to issues of policy, governance, and performance monitoring (as opposed to, for example, community linkage, representation, and advocacy, or community empowerment and control). Largely absent (but not entirely, as there were four exceptions: Chair 3, 5, 10 and CAN 4) are fiery or passionate descriptions of empowered boards looking out for community interests, and in its place were itemized listings of daily, weekly, monthly, and annual practices engaged in as governors, overseers, liaisons and interfaces.

Interestingly, the descriptions that resulted from the interviews were highly detailed and yet, paradoxically, vague; RHA members read, considered, and listened, yet

the significance of this work was rarely articulated. This absence may in part be explained by its unproductive nature; the work neither produces a good or a service, but involves the “busywork” of monitoring the system.

I think of it as busywork .... they work away and ... I don't mean to be derogatory there, but I think it is “busywork” for them. And ... we have a branch here that trains them to be busy in their work (laughs), and I think ... the managers have to have somebody to talk to, they work away at their work and they have to have somebody to give it to .... They give it to the board and the board says “that is good,” maybe “fine tune here.” “Thank you very much.” It has been blessed by the board. (Ministry 6)

*What does your board do?* We have meetings! (laughs) .... We get lots of monitoring reports, lots and lots of reports. (Chair 1)

Although this Ministry official “doesn't mean to be derogatory,” characterizing the board's work as “busywork” devalues it. Busywork refers to “activities...meant to take up time but not necessarily yield productive results” (The Free Dictionary, 2011); “work performed simply to keep oneself occupied” (The Oxford English Dictionary, 2000). Moreover, as the official explains, people within the Ministry train board members, thus narrowly circumscribing the parameters of the boards' work. Monitoring the system is unproductive labour; boards are consumed with day-to-day technocratic practices (“we have meetings... get lots of monitoring reports”) that form managerial oversight with accountability to the Ministry for performance. RHA members are not busy with community engagement, public accountability, oversight on behalf of citizens, etcetera.

#### **4.6 Technocratic Logics**

The interviews provided a sight line into the guiding logics and frameworks within which practices were produced and shaped. This overarching framework strongly resonated with technocratic logics. Recall from Chapter 2, the definition of a technocratic logic as an internal, health system-directed, planning and efficiency logic, wherein RHAs

contributed to better systems. This logic is as compared to, for example, more externally focused democratic logics, that advocated RHAs and local citizen participation as routes to healthy public spheres and democracy, or population health logics, advocating RHAs and community participation in governance as routes to population health gains.

Much of the detail and descriptions shared in the interviews resonated with technocratic logics. Interviewee descriptions and discourses constructed regionalization and its practices in terms of plausible benefits and effects for the health care system (as opposed to its effects on the public sphere and democracy, or its empowerment effects and its potential to support population health gains). Regionalization was positioned as a route to better planning and executing services and systems and overseeing these plans and their execution at a local level. Regionalization was rarely articulated in terms of democratic relations (although traces of such did occur and will be discussed in the next chapter) and was never discussed in terms of empowerment and population health effects.

While technocratic logics and practices permeated the interviews, it was particularly salient within discussions as to the specific roles, functions and practices of the RHAs, both in and of themselves and in relation to the other central actor groups considered within this research. The primary and active role of RHAs was in relation to its system-oriented functions (e.g., preparing for and attending meetings, hearing CEO ideas, liaising with the Ministry, ensuring the CEO and Minister were informed as to local issues and community reactions, etc.). Its more passive and less articulated roles were in relation to its public and community connectivity. Community connections would help the system fine-tune and adjust plans; it was not about public accountability or giving community members an opportunity to exercise local control.

#### **4.7 Emerging Forms of Governance**

Although RHAs styled themselves as “governance” boards, in practice, they operate as an administrator on behalf of the central-administrative state, with formal accountability to it. In this style of governance, the RHAs are not empowered to direct and steer its organization (on behalf of constituents, publics or communities), the authority to steer and direct rests with a central-administrative state (i.e., the Minister and Ministry), ultimately accountable to the public/electorate. The RHAs operate on a model of governance wherein they have responsibility for limited strategic guidance (constrained by Ministerial priorities and accountability demands), and instead attend to managerial oversight and monitoring (as enabled via CEO practices of informing and educating the board), whilst remaining outside of operations. Although not formally accountable to the public, the RHAs interfaced, liaised, and surveyed public and community sentiments to help inform the system and serve as sensors ferrying information into the system and out to publics.

Much of the authority of the RHAs is dispersed to the CEO (whose sphere of influence and decision-making RHAs were to stay out of) and the Ministry (who has ultimate decision-making powers and authority). Alignment of these lines of authority enables the system to work more coherently while overstepping them could lead to tension. Indeed, two CEOs (CEO 4 and 8) commented that the Ministry increasingly took up the traditional roles and decision-making domains of the RHAs, and one CEO noted that RHAs served as volunteers “with no levers” (CEO 5). At the same time, one Chair commented: “quite often, management gets into the role of the Board” (Chair 8).



If the region *does*, while the Ministry *guides* and ultimately *approves*, what exactly is it that the RHA is left to do? The evidence from the interviews suggests that a new form of governance board is emerging, one based upon accountability to the central-administrative state (not publics and communities), and one wherein the board serves as an extension of the state and system (more so than of publics, communities, and lifeworlds), performing as local administrators (who manage) more than actual governors (who steer and direct). This description of an emerging type of governance board (one that functions as manager not guide) will be extended in Chapter 5. In particular, Chapter 5 presents three emerging themes from the interviews, namely that RHAs are boards that: (a) serve as “eyes and ears,” watching, listening, and surveying communities in lieu of public accountabilities; (b) prioritize “regional over local” agendas and issues; and (c) pit formal, “expert” knowledge against informal, community connection.

#### **4.8 Summary**

This chapter presented the meso- and micro-level practices of regionalization in Saskatchewan. The Minister and Ministry authored formal policies, but some power to mediate and shape local interpretations and practices lay everywhere. A cohesive and mundane narrative emerged, one heavy in technocratic logics, wherein busy boards engaged in practices supporting administrative oversight and attention to agendas of health system performance. These roles and agendas are in contrast to those attending, for example, more directly to issues of governing and steering, providing public accountability, or ensuring community engagement. The practices and agendas encourage attention to and regulation of internal gazes on finance, client and employee satisfaction, quality, risk and safety, resource utilization, and so forth. Although a few Chairs cited

counter-examples, the majority of interviewees cited RHA accountability to the Ministry, not publics (this theme will re-visited in the next chapter). Given that RHA members, being volunteers (with a per diem), perform their duties in addition to other life duties, and given that their practices have them busy with governance and oversight, there may well be little time left for more externally focused agendas that attend to issues such as public accountability and engagement.

Technocratic logics, while prevalent, were not the only ones that appeared within central actors' discussions of regionalization. Democratic traces appeared within some topics and some interviews, and these traces are the focus of the next chapter.

## **CHAPTER 5: TECHOCRATIC-DEMOCRATIC HYBRIDIZATIONS, ACCOMODATIONS AND TENSIONS**

Chapter 4 presented central actors' interpretations and practices of regionalization, centering on the roles and functions of the RHAs and the RHAs in relation to the three other actor groups central to the regionalized governance model (CEOs and health regions, Minister and Ministry, and CANs, communities and publics). While much in the interpretations and day-to-day practices reflected an overarching technocratic framing for regionalization, democratic traces did persist and they will be the focus of this chapter.

In some contexts, these democratic elements appeared as occasional traces that were readily accommodated within the overarching technocratic framework (e.g., section 5.1 and discussions of why regionalize the system, and section 5.3 and discussions of local accountabilities and why engage publics). In other contexts, the democratic elements appeared to have hybridized with technocratic framings and the two logics simply co-exist, with framings and practices that readily alternate between the two, depending on the situation (e.g., section 5.2 and discussions of the dual roles of RHAs and their work as sensors). In yet other contexts, the democratic traces can be seen to exert subtle tensions and contradictions with the broader technocratic framings (see section 5.4 and discussions of the knowledge contributions of community board members). These latter sites foreshadow spaces of more active contestation that may disrupt the dominant logic, or that may be accommodated or displaced by it (Clarke, 2007).

While democratic framings wane but linger, population health logic do not appear to have been sustained. This chapter closes with a brief discussion of this absence.

## **5.1 Democratic Traces: Why Regionalize the System?**

### **5.1.1 Formal Pronouncements**

Early writings on health system reform and regionalization noted its potential contributions to population health, democratic health, and health system health (see Chapter 2). The then NDP government argued that regionalization could be more than simply a structural reform of the system and its governance structure. Regionalization was posited to offer the potential for radical reform, the most radical, according to some observers, since the introduction of Medicare (Lomas, 1996; Lomas et al., 1997).

This radical restructuring was evident in the Government of Saskatchewan's publications introducing the 1992 reforms (Saskatchewan Health 1992a, 1992b, 1992c), as well as in the Legislative Assembly. During the preamble, introduction, readings, and Royal Assent of the *Health Districts Act* (Hansard transcripts, April 27, 1992 to May 4, 1993), the Government's speech consistently called on notions of "cooperation," "community empowerment," and "community control." In addition, then Health Minister Louise Simard introduced the concept of the "wellness model," an approach to health and health services based in health promotion and illness prevention, as opposed to a more narrow focus on medical care and services to treat the ill.

Although the Government's guiding frameworks posited an overly romantic (and perhaps naive) version of regionalization, their discourses for the 1992 reforms were framed (at least in their more public discussions) within population health logics (i.e., public participation and community involvement is empowering and thus health

promoting) and democratization arguments (e.g., democracy is strengthened with local citizens governing local services). The announcements positioned health boards as sites of community empowerment, engagement, governance, and accountability, with citizens and communities actively planning and overseeing *their* system. This language and these terms continued to be called upon after the passing of the Act, after the resignation of Minister Simard (Hansard transcripts, February 1995), after her replacement by Minister Lorne Calvert, and through to the closing of the 22<sup>nd</sup> Legislature.

By the opening of the 24<sup>th</sup> Legislature, however, the Government's public discourses had shifted, and new and clearly technocratic logics were called upon<sup>41</sup>. Reform was now framed in terms of efficiency and effectiveness, and gains would come via evidence-based decision-making and centralized planning. The main issues to be addressed by these reforms were: access to medical services, wait lists, facility closures and conversions, recruitment and retention of health care providers, clarity of roles and responsibilities for the actor groups, and a close and constant scrutiny of the administrative costs associated with the District Health Boards (e.g., Throne Speech, December 6, 1999). These technocratic framings were embedded in the new *Regional Health Services Act* which the then NDP Health Minister John Nilson described as “a new regime of accountability” among the RHAs, the government, and other health system partners (Hansard transcripts, June 5, 2002).

Although the Government did not stop entirely calling on prior rhetoric (traces of the initial “community involvement” framings made occasional appearances, see for

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<sup>41</sup> During the 23rd Legislature, references continued to be made to empowerment, local control, and accountability, but sporadically and in much weaker forms. Elements of these logics are briefly referenced in the opening Throne Speeches for the first, second and third sessions of the Legislature (Hansard transcripts, February 29, 1996; March 6, 1997; and March 9, 1998).

example, Pat Atkinson, Hansard transcripts, April 4, 2000), the concepts of accountability to and control by local communities were dropped as reference points. The 2001 amendment text was free of any reference linking health system reform and regionalization with its initial and more radical framings of citizen engagement, public participation, or empowered communities.<sup>42</sup> Instead, the opinions of patients (not citizens or communities) were to be solicited as consumers of health care services. When references to cooperation were made, they were most often in the context of cooperation between districts and providers, not cooperation between districts and communities (e.g., Hansard transcripts, March 15-31, 1999), or cooperation among the districts, the government, and the Ministry (e.g., Roy Romanow, Hansard, April 27, 2000; John Nilson, Hansard, June 1, 1999). These Hansard transcripts help to demonstrate the morphing of the discourse from its early references to community control to its later references to “public input” and “community consultation” (e.g., John Nilson, Hansard, June 5, 1999; Hansard transcripts May 1-31, 2001).

Despite this shift, population health logics continued to be evident in the public discourse as the NDP government made frequent reference to the determinants of health (e.g., Judy Junor, Hansard transcripts, April 4, 2000; Kevin Yates, Hansard transcripts, May 16, 2000; Roy Romanow, Hansard transcripts, June 29, 2000) in its introduction of tobacco control legislation, safer communities acts, and so forth. In this way, the NDP government updated its population health logic of 1992, moving away from one that combined democratic ideas of local control with calls for community empowerment, to a

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<sup>42</sup> The Opposition continued interrogating the Government on issues of local control and frequently equated regionalization and the DHBs with a loss of local control (e.g., Brenda Bakken, Hansard transcripts, April 3, 2000; April 13, 2000; Arlene Julé, May 16, 1999; Rod Gantefoer, June 14, 2002).

streamlined logic that called on illness prevention and health promotion activities based on individual behaviour rather than community responsibility.

### **5.1.2 Central Actors' Interpretations and Understandings**

It is onto this shifting terrain and within the morphing logics that the interpretations and practices of the central actors' took shape. When asked as to their understanding as to why the system was regionalized, the central actors most frequently cited efficiency gains and potential cost-savings (Chair 1-3, 5, 7, 9, 10; CEO 3, 5, 6, Ministry 3, 4). Other reasons included increased manageability, integration, and coordination of the various sub-sectors of the system (Chair 1, 4, 7-11, CEO 2-5, 7, 8; Ministry 1, 3, 5). Interviewees believed efficiency gains could result with reducing the number of boards. They argued that there were too many DHBs after the 1992 iteration of regionalization, and while the 32-districts contributed to system alignment, the number of districts contributed to a still unduly fragmented system, rife with service inconsistencies across the province (Chair 7, 8; CEO 4, 7; Ministry 3, 5, 8). Furthermore, interviewees commented that under the 1992 model, smaller districts often faced resource issues and failed to have the "critical mass" (Chair 3, 5, CEO 2-7, Ministry 3 and 6) believed necessary to resource an efficient and effective system. For example, smaller districts had difficulty attracting senior leaders and trained providers, and some interviewees believed that by amalgamating the districts into regions, there could be gains in the ability of smaller regions to attract and retain staff (Chair 4, CEO 2-5, 7, Ministry 6). Some interviewees added that the 2001 amalgamations represented a "natural progression" (Ministry 4) and "evolution" (CEO 5) of regionalization, boosting gains made under the 1992 model (Chair 2, CEO 5, Ministry 1, 4).

While the majority of the central actors posited that regionalization was necessary to improve system efficiencies, for a subset of Ministry officials, the 1992 reforms were a means of devolving (Ministry 7) and de-centering decisions (Ministry 1), in part to deflect criticism for the significant reforms that were needed (Ministry 6). But the 2001 amalgamations were a conscious decision on the part of the centre (i.e., the political administrative state) to forgo decentralization and instead increase central planning and control (Ministry 6, 7 and 8). This strategy appears to have been fueled in part by policy failures from boards (e.g., significant deficits, inter-district competitions, and intra-provincial service gaps) (Ministry 1 and 8), and in part, by publics that continued to hold the government accountable for DHB decisions (Ministry 1, 6 and 8). Strikingly, this line of comment was unique to Ministry interviews and did not appear in Chair or CEO texts. These findings of power concentration echo those of Martin (2008), who, based on key-informant interviews, concluded that a preoccupation during regionalization reform in Saskatchewan was increased control over health care by the central government.

While the majority of central actors' explanations and reasons for regionalization and re-regionalization were rooted in technocratic framings and understandings (i.e., it is for the health of the health system), democratic traces did appear. For example, occasional comments suggested that the 1992 reforms were at least in part about democracy and local decision-making (CEO 6), the devolution of powers (Ministry 7), increasing the reflexivity of the system (Ministry 8), and increasing opportunities for public involvement (Chair 11, CEO 3) and local input (CEO 4).

When asked for their understandings of CANs, many interviewees reported that the advisory networks were introduced as a vehicle to maintain participation and local



input (9 of 11 Chairs, 4 of 8 CEOs, and 6 of the 8 Ministry interviewees made this comment). At least one Ministry official (Ministry 6) believed that the CANs ensured grassroots connections between system and community within the regionalization framework. With the reduction of boards from over 400 facility boards, first to 32 district boards, then to 12 regional boards, interviewees recognized that there would be public pressure for input, and they were sensitive to perceptions of reduced opportunities for input. That CANs were introduced as an optical solution to these reduced opportunities rather than as an actual solution, was explicitly suggested in one interview:

I mean Community Advisory Networks, quite candidly, were a political sop at the end of the day because they were afraid that with going from 32 to 12 ... people were going to lose input into the system. (Ministry 5)

Others echoed this idea, suggesting that CANs were to “appease the public” (Chair 8) and their “pressure for input” (Chair 1), and give “a sense of input” (Chair 3), especially with the reduction of boards from 32 to 12 (CEO 4). Clearly, there was some understanding by interviewees that CANs were about deflecting criticism.

After broader discussions, interviewees were asked whether they understood regionalization to be, or had heard regionalization posited as, a means to (a) democratize the health system, opening it to more public ideas, input and voice, or (b) population health gains wherein, for example, communities would make local decisions as a route to empowered, healthier communities. While some interviewees agreed that these ideas may have been part of the thinking (Chairs 2-5, 8; CEO 1, 2, 6, 7; Ministry 3) and were “honorable but naïve goals” (Chair 3), other responses ranged from simple “No, I hadn’t heard that” (Chairs 1, 7, 11, CEO 4, 5, 8 and Ministry 6), to laughter and sarcasm.

[Democratization] Right. Right. Wonderful political ploy wasn’t it? Empowered communities, God, “well sure, golly eh?” You know “let’s have some pie here.” (laughs) (Ministry 1)

### **5.1.3 Summary**

Actors were quick to position regionalization within technocratic framings (e.g., calling on logics of service efficiencies, system coordination, and critical masses, to benefit the health system), and a coherent narrative emerged of regionalization for the purposes of system efficiency and effectiveness. While no comments reflected population health framings (e.g., ideas of empowerment and community engagement for the benefit of populations and health), democratic traces occasionally could be heard, for example, in ideas of community representation and public input into system decision-making through RHAs and CANs. These patterns parallel those of the Government's speech and public discourse and was repeated in other sites within the interviews. Thus, while regionalization appears to be constructed and practised primarily within technocratic framings— it is about improving the health of the system —occasional democratic intentions still linger. Although the use of sarcasm and laughter may suggest attempts to marginalize these remaining residues, little other evidence suggests that the democratic traces create dissonance; rather, it appears that they are simply accommodated within the more dominant technocratic framings.

### **5.2 Technocratic-Democratic Hybridizations**

In some sites within the interpretations and practices of the central actors, democratic elements appeared to co-exist alongside the technocratic framings. These findings parallel those of Martin (2007), whose discourse analysis of National Health Services documents showed public participation to be positioned neither solely within technocratic logics (reducing publics to consumers and patients with knowledge and expertise to offer planners), nor democratic logics (raising participants to representative

citizens and empowered decision-makers), but rather both logics simultaneously. These hybridizations appeared here within presentations of a dual role for RHAs and descriptions of their role as sensors for lifeworlds and systems.

### **5.2.1 “Dual roles” for RHAs**

We try to be proactive, but on the other hand, we also try to listen to the people as well. So, we try to lead, but we also try to listen, so I think we have to understand that it's kind of a dual role. (Chair 8)

This opening quote exemplifies a dual construction to the RHA role: at times, RHAs served primarily on behalf of, and in the interest of, the system (i.e., technocratic logics), helping the system by monitoring, managing, liaising, feeding it information to help keep it ahead of local and regional issues, and so forth. At other times, RHAs served primarily on behalf of, and in the interests of, the publics and communities of their region (i.e., democratic logics), engaging with publics to understand local issues and needs, to then better represent these views to the system (i.e., the RHA, the CEO and region, the Minister and Ministry) during discussions, deliberations, and decision-making. In these ways, RHAs extend the interface between the system and various lifeworlds, ferrying information back and forth, at times extending the system, at other times extending lifeworlds. RHAs thus operate in a liminal space between lifeworlds and system.

This bi-focused role was repeated throughout descriptions of RHA practices in relation to the CEO, the Ministry, the CANS and communities. The distinction between serving (primarily) interests of the system or publics is subtle, but in the context of discerning technocratic from democratic governing logics, it is a central difference between the two logics. Dual roles for the RHAs in relation to the CEO were seen (see section 4.2.2) when RHAs served the interests of the system (e.g., serving as a sounding board for the CEO and a sensor for the health region and system) and those of lifeworlds,

publics, and communities (e.g., serving as a public voice in the system). Dual roles were described for RHAs in their relationship to the Ministry (see section 4.3.2) when RHA roles were oriented towards serving the system (e.g., alerting the Ministry and helping the system stay abreast of local crisis and diffuse “uproars”), or at other times, towards serving lifeworlds (e.g., pushing for local consideration and support when liaising with the Minister). Dual roles were also seen for RHAs when they were relating to CANs and communities (see section 4.4.1). In one facet of this role, RHAs represented system-views to lifeworlds (e.g., educating publics as to the system and disseminating health system and health region information to them). In a second facet of the role, RHAs represented lifeworld views to the system (e.g., listening to and gaining appreciation and understanding of community issues, concerns, and experiences, information that RHA members then relayed to the system).

The duality of the role was apparent not only across central actors’ descriptions, but also within single interviews. For example, one actor first positioned the RHA role within a technocratic logic in which the role of an effective board member is to manage the message of the system:

If it happens in the community than a board member should maybe be aware of it [the message] so that if he is confronted or stopped in the street he has a response. And we encourage our board members “unless you really think you need to share that something is wrong, just to, you know, to not elaborate on the issues out on the street or anywhere because it just gets you into deeper trouble every time.” [laughter] And sometimes you have to be able to answer the public. We have to give an answer, you can’t just say, “Well, I’m not going to say” because the minute you say that, “Oh I can’t comment” oh boy, then they are mad, and the rumours really start flying. [We] develop a strategy sometimes, at the board level, as to how we’re going to respond to those things. (Chair 3)

As seen in this quote, the speaker positions RHA members within the system (not the community), and constructs for them a role in mitigating community inquiries with pre-

packaged messages and considered replies. Later in this same interview, however, this Chair repositioned the RHA role within more democratic interpretations.

People have the right to know. These are public funds that we are spending you know, so let's make sure we spend these public funds in the best way possible. (Chair 3)

As seen in this statement, the speaker now moves from positioning RHAs within the system, mitigating community inquiries with formulated replies (as seen in the first quote) to positioning RHA members within lifeworlds, with accountability to publics.

Through these roles and relations, the RHAs served as a nexus between system and lifeworlds, with roles that oriented primarily toward one or the other, depending on the situation. In the context of the boardroom and meetings with the Minister and Ministry, the RHA could be a representation of community. In the context of community (whether on “coffee row”, the church steps, or attending public meetings), board members could be a representation of the system. They are a “region-community interface” (CEO 5), and serve interests of *both* the system (e.g., ferrying system information to the lifeworlds) and lifeworlds (e.g., ferrying lifeworlds’ norms and wishes to the system).

Depending on system reactions to the latter (i.e., lifeworlds’ interests and information ferried in), the potential exists for this flow of information to yield democratic effects. For example, a democratic pulse could be felt when a system response respects lifeworld information and uses it to shape its response. A subtle but significant shift is seen with a technocratic reaction, wherein the system responds to lifeworld information by tailoring subsequent messaging in an attempt to influence lifeworlds, selling ideas, and making community more amenable to system plans. This is the difference between (a) hearing a community concern and altering a plan of action in

the interest of the community, and (b) hearing a community concern and not changing the decision, but changing the messaging of the decision to maintain the system's decision.

Within this hybridized role, technocratic and democratic logics co-exist, quite seamlessly and with a fluid shift back and forth between the two. This blending was further demonstrated in a specific articulation of an RHA role, the RHA as sensor.

### **5.2.2 RHAs as “Eyes and Ears”: Looking Out / Looking In**

The Habermasian concept of “sensors” (Arato & Cohen, 1988: 472-480; Habermas, 1987a; 1996a: 359) denoted civil society organizations situated at interfaces between lifeworlds and the system, and serving as potential sites through which lifeworld influences could be ushered to the state, in a democratizing fashion. This idea was articulated by central actors in the present research in their expression that RHAs (and CANs) served as “eyes and ears” for the health system. This exact phrase was volunteered in ten interviews (4 Chairs, 4 CEOs, 2 Ministry), but its intention was captured in many more. The frequency with which RHAs (and on occasion, CANs) were described as “eyes and ears” to the health system was an unexpected theme arising from the interviews, and the descriptions that accompanied this term aptly exemplify the duality to the role of community board member.

The “eyes and ears” role was positioned in multiple ways. In one articulation, it was embedded within democratic intentions, wherein, as “eyes and ears” members were to listen, watch, and then bring a community-informed perspective to the RHA table.

I actually see that [RHA members] bring to bear something different from what the CEO and Senior Leadership team bring to the organization. They bring with them, regardless of issues of accountability or legal responsibility, they bring a broad, community perspective. They are eyes and ears on the issues, needs, and concerns of their communities, and they

bring those to the table in a way that we, as a management team, probably can't, or not as richly as board members can. (CEO 2)

Other articulations of the eye and ear role were ambivalent, not aligning clearly with either democratic or technocratic logics, but could be interpreted as either.

They're kind of your eyes and your ears, that's what I think of them as. If there were concerns, if they see issues out there, hopefully they would bring them forward. (CEO 4)

In still other articulations, the role was embedded within more technocratic, instrumental constructions of the role, wherein information gleaned while watching and listening would be ferried to the system to guide subsequent communications (as opposed to, for example, using the information to guide subsequent actions or decisions).

[RHA members] are intended to have a connectivity with the local population ... they are, in effect, local eyes and ears ... providing community feedback and keeping a finger on the pulse of community expectations ... aspirations ... challenges that you can do something about. So they become eyes and ears, this is the word on the street, that such and such happened, and so you can pick up from that, and guide your communications and do your investigations accordingly. (Ministry 3)

These variations in articulation and intention for the watching of and listening to communities appeared not only across interviews, but within interviews as well. For example, in the following quote, the speaker moved from more democratically guided logics (where RHA members were a contact for publics and a site with whom publics could share concerns and ask questions), to more technocratic framings (where RHA members were eavesdropping and listening in on conversations of publics).

You are also ears and eyes in your community. People soon learn, they know who is connected to the Health Board and they are not hesitant to call. They know our numbers, they stop you on the street or wherever you are, the grocery store, watching a hockey game, walking in the park, wherever. Sometimes too, it's like eavesdropping ... you hear people talking about something and they don't have a clue that you are connected but it's what you pick up. It's that sense of how are we actually doing? What are people's opinions? (Chair 6)

As this Chair observes, being “eyes and ears” in a community could be direct (individuals phoning or stopping members in the street while engaged in day-to-day activities) or it could be more surreptitious. However, one interviewee extended the metaphor of “eyes and ears” and more firmly embedded this role within a technocratic logic by inculcating RHA community members in to the role of “spies” (CEO 6).

They also have good antennas in the communities, so if they pick up that things are going well, they’ll let us know. If they pick up that thing aren’t, they’ll let us know or give me a heads up. So in some ways they’re, well I use the term spies, but they are the ears of the RHA that’s out there. .... They’re the ears of the community (CEO 6)

The expectation that community members would serve as “eyes and ears” was ascribed to CAN members as well, as seen in the following exemplary quotes. In the first example CANs are constructed as support to the CEO.

My belief is that what CANs are doing is again bringing your community eyes and ears to the table. It is more environmental information. It is more perspective. ... I love having 12 eyes, ears, whatever, on a number of communities around [the region]. Why wouldn’t [the board], in turn, want to make that 40 or 50? (CEO 2)

In a second example, CANs are supporting the RHA in its role with the region.

[And CANs] I suppose, provide feedback to a board relative to how well programs and services were received, to be eyes and ears for community perceptions that the service is working or not working. (Ministry 3)

Finally, in this third example, CANs are constructed as support to the RHA, but this time in its role with the Ministry (as opposed to the region).

We’re supposed to have our ear to the ground and, you know if we’re able to share that with the Minister and with government ... If we’re supposed to have our ear to the ground, then we should be hearing something right? So, our CANs are to tell what’s going on in their community. (Chair 1)

Unpacking this simple phrase to consider its subtle meanings, nuances the democratic-technocratic duality. In its more technocratic articulation, the discourse and



practices do not position RHAs as agents *for* the people, whom they represent and on whose behalf they serve in the RHA role. Nor does this articulation of the role position RHA members as eyes and ears *for* the people--watching the system, ensuring public and community interests and values are considered and respected (although this possibility is not ruled out). Rather, community members serving on RHAs (and CANs) are positioned as agents *for* the system, rooted in concerns of the bureaucratic system and serving as “eyes and ears” in their communities, listening, hearing, watching, taking the pulse, and feeding this information back to the system.

Community information and feedback, however it is obtained by the “eyes and ears” (e.g., spying, eavesdropping, conversations with and phone calls to identified board members, etc.), can be fed to the system and the system can then make adjustments that reflect the interests and concerns of publics and communities and/or the system (or both, if their interests align). Depending on the situation, either and both facets of an RHA member’s bi-focused role can be activated. Embedded within this potential, is the opportunity for publics and communities to pulse the system and in this way, to serve democratic interests.

While RHAs (and CANs) serving as “eyes and ears” offer the potential to ferry lifeworld information to the system in a democratic fashion, comments also suggest an instrumentality. In effect, the interfacing can be colonized to serve system interests (helping it to adjust, avert crises, and govern). This articulation of the sensor inverts that posed in Habermas’s normative model of deliberative democracy, in which public spheres bundle and energize lifeworld opinions, norms and values, to then pulse the decision-making bureaucratic system.

### **5.3 Democratic Accommodations Within Technocratic Framings**

As with discussions of why regionalize the system (see 5.1), traces of democratic intentions were evident in the interpretations of a few actors who reported informal, local accountabilities and for a few actors within some of their reasoning for public participation. In both of these areas, these traces appear to be easily accommodated within the broader technocratic framings and while they produce a slight disjuncture between the ends and means of the policies (at least in *some* interpretations for *some* actors), they create few, if any, overt signs of contestation and tension. These democratic traces appeared to be easily accommodated by the broader technocratic framing.

#### **5.3.1 Competing Targets: RHA Accountabilities**

Accountability contains many elements, including the relationship between the decision-makers and the affected; responsibility for decisions and actions; authority to conduct and delegate; answerability for decisions; performance; and sanction (Fooks & Maslove, 2004). As detailed in Chapter 4, formal and informal accountability ties existed between the RHAs and the Ministry (see section 4.4.3). As a group, the interviewees discussed accountability in terms of relationship *with*, and responsibility and answerability *to* the Ministry. A few interviewees, however, also cited informal ties between board members and their communities, and this relationship offered the potential for informal public accountability ties in addition to those to the central-administrative state.

I was born and raised in this community, and you know, I have got friends and family that I have to face everyday.... So, I mean, for my personal perspective, I feel its very important to me to do the best I can, to provide for the community, and to tell them the truth, and be honest and be accessible, you know, if they have questions. ... I think it is important that

the community is represented well, and then, if we don't, what are we there for? (Chair 10)

Depending upon the individual member of the RHA, they may feel a very, very strong sense of responsibility to the local community in which they live – almost a representative function – even though they clearly, legally, do not have that. (Chair 2)

I don't think that we should discount that it's not easy to walk down the street in your home town and it is small and everybody knows you and you made a decision that was critical that the community believes to their longevity or their economic health and you as a board member have participated in shutting it down. (CEO 7)

These examples demonstrate the dual nature of RHAs' accountability that is structured by their social proximity to their communities, and their structural ties to the administrative state. Based on a sense of place, some RHA members are part of the communities – they were “born and raised there” and therefore, they are accountable to the community to “do the best,” “tell them the truth,” and “be accessible.” Some RHA members cited “a very strong sense of responsibility to the local community,” even though this “representative function” is not endorsed legally. At the same, as the third speaker makes clear, these close connections and informal ties make board members more vulnerable to direct (and possibly personal) criticism when a decision of the RHA negatively affects a community.

With these informal ties between RHA members and their communities, community ties and public accountability (logics heavily called on in the 1992 introductions) persist, for at least some Chairs. As with their dually tuned “eyes and ears,” there appears little overt friction with their dual accountabilities. These democratic traces seem to have been accommodated within overarching technocratic framings and practices. This is no doubt aided by the relatively small numbers of RHA members reporting overt local accountabilities, the power of the formal accountabilities to quash

local tensions should they arise, and the relative period of ease during which the interviews were completed. If the interviews had been completed in the midst of crises or major reform (e.g., facility closures or service conversions), these tensions may have been amplified (or silenced).

### **5.3.2 The Who, How and Why of Public Participation**

Public participation can be expressed in multiple ways (see section 2.3.2), ranging from information provision and input to consulting and participating in decision-making though to publics leading and controlling decisions (Arnstein, 1969). In its more technocratic framings, public participation within health system governance and management would serve to educate publics and encourage their support for the system. In its more democratic framings, public participants would represent lifeworlds, guiding and steering the publicly funded system as per their collectively deliberated values. Complex, hyphenated framings of public participation can also exist wherein, for example, citizen-users are engaged in planning and managing services (Davies et al., 2006; Tritter & McCallum, 2006). As Martin (2007) posited it, public participation has become a technique of governing, one that serves to increase the governors knowledge of the governed, while providing a vehicle through which the governed can make their needs and desires known.

Within the current research interviews, when actors were asked their understanding of public participation within the regionalized model of health system governance, the pattern repeated wherein their interpretations reflected a predominately technocratic approach that easily accommodated their more sporadic and occasional democratic framings.

### 5.3.2.1 Who is Engaged?

When central actors were describing whom they considered as the publics and communities of the health region with whom the health system should be engaging, in addition to generic references to “everybody” and “people in the community,” interviewees primarily called on three broad groups. The first group interviewees called on consisted of people who could provide different perspectives (e.g., geographical groupings, socio-cultural identity groupings). The second group cited by interviewees consisted of patients and their families, people who could be directly affected by the service changes or issues under consideration. Patients and families were positioned as contributors of knowledge and experience to the system, and whose information could increase the responsiveness of system to public demands. The third group commonly called upon was “the stakeholder group” (i.e., groups with shared interests), and “partners” (e.g., people and groups who could collaborate with regions and RHAs in problem solving and program planning initiatives). Specific examples cited included Tribal Councils, school and education boards, municipal and town councils, and senior citizen associations.

Notably absent in the listings were references to health care workers and service providers or their representative groups (e.g., nurses, doctors, labour unions, SAHO, etc). Neither did interviewees describe efforts to hear from more typically marginalized people or groups not readily tied to or adequately represented via these larger collectives (e.g., people living in poverty, the non-“active” citizen, the civic illiterate, etc.), although a few RHAs did target youth on their advisory networks, as an attempt to extend their reach beyond more typically consulted publics.

### **5.3.2.2 How are Publics Engaged?**

When describing how publics and communities participated (e.g., the particular venues and formats), interviewees primarily cited formal means of engagement (i.e., planned, structured and prepared meetings) with occasional reference to less formal vehicles (e.g., random conversations and meetings in daily lives and in public spaces). At times, RHAs were positioned as groups who planned and structured engagement opportunities for others, while at other times, RHA meetings were positioned as public participation venues between RHAs and the health regions, wherein RHA members themselves were positioned as the publics engaged. This pattern also held for CANs who, at times, were positioned as participation venues and opportunities for RHA members to hear from and engage with publics, while at other times, CANs themselves planned and structured engagement opportunities between themselves and other publics.

### **5.3.2.3 Why are Publics Engaged?**

When discussing why publics and communities should participate and be engaged, publics tended to be constructed as groups to be consulted and approached for their reactions to system-guided planning. In these consultations, publics would represent their broader groups and identities, and passively contribute knowledge and lay-expertise to the system. Publics were not positioned as active and empowered, decision-making groups to whom service planners and providers were accountable, but rather as groups with complaints and concerns that planners and providers needed to transform into manageable wants, needs, and service delivery guides.

In addition to these more technocratic framings of public participation, participation was occasionally positioned within democratic framings wherein public

participation was a means to insert public information into the system. Occasional comments were made that RHAs were to not function “in a vacuum” (Chair 2) and were to connect with and hear from publics and then bring this information, knowledge, and perspective to their board work, discussions, deliberations and decisions. Community connections were also to help the RHAs, regions and Ministry staff understand the people served by the system and region (Chair 1, 3, 5, 7-10, CEO 2), what various situations and issues these communities are dealing with, and public expectations. As well, connections could help ensure that the health system and health care is considered from perspective of citizens (not just the system, Ministry, health region, staff, etc.). These community connections were described as routes for local input into and influence on the system, and RHAs were described as the “common man’s (sic)” connection to the system (Chair 1). Having RHAs maintain community connections was valuable in that these connections could reduce the perceived social distance between the health region and communities, help assuage public fears and keep them happy, and ensure that communities were looked after and considered. In particular, an RHA’s connections with its various communities enabled the RHAs to consider the perspectives and the material realities of the lifeworlds of publics and communities when making decisions.

If you traveled from [community A] then you don’t forget how far people have to travel for health care services. It’s easy if you are just sitting here, it is easy to forget how far they have to travel. It’s not saying that people sitting in a central office somewhere wouldn’t be aware of that, but when you are living it, it’s more real to you. (Chair 7)

In this case, the material reality of traveling from one community to another is a good reminder for this Chair of the everyday experiences of individuals and their families when accessing health care services. This Chair recognizes that “it is easy to forget how far people have to travel for health care services” when you are sitting in an office that is

both geographically, and perhaps socially, removed from a community. Although members of RHAs may be intellectually aware of these challenges, they don't embody or "feel" them unless they "are living it, [then] it's more real."

#### **5.3.2.4 Summary**

These findings indicate that "public participation" has been simultaneously constructed within both technocratic and democratic logics—although it was heavily weighted to the former. Public participation serves to both ferry information in and out of the lifeworlds, and in and out the system. Framed as a governing-mentality, public participation is assisting both the governors and the governed (Martin, 2007). Public participation was articulated in a variety of ways in the interviews, ranging from accountability of RHAs through their informal ties to local communities to the (mostly) formal ways in which RHAs engaged with particular constituencies, the strategies with which they engaged them, and the kinds of information that the RHAs were hoping to solicit. Often community engagement by the RHAs was a mechanism to support decision-making and planning (a technocratic logic), but communities were sometimes consulted and provided input into and had influence on system decisions (a democratic logic). Publics were positioned with knowledge to contribute (as per more technocratic intentions) and as sites to be represented (as per more democratic intentions). Embedded within this pattern is an occasional disjuncture between the means and ends of public participation policies, wherein occasional democratic ends are overlooked within technocratic means and practices. Although largely blended and accommodated, with different climates and contexts, these democratic traces have the potential to be amplified and prioritized, accommodated, or marginalized and erased. There were no references to



empowerment, local decision-making, or other phrases that resonate with population health logics, suggesting that these original Government framings have been all but erased from the interpretations, discourses and practices.

#### **5.4 Technocratic – Democratic Tensions**

While the previous sections of this chapter detail sites of blended and hybridized logics, and sites wherein technocratic logics appear to easily accommodate occasional and sporadic democratic traces, discussions of the knowledge contributions of RHA members revealed more readily visible sites of tension. These sites of contestation have the potential to influence future articulations and practices. The first such site of tension, and by far the most overt, appeared within a few interviews where expertise was pit against community knowledge. The second site of tension was embedded within a phrase volunteered in the interviews with such frequency that it became a defining theme in the data -- the expectation that board members carry “no agenda,” serving “regional not local interests.”

##### **5.4.1 Knowledge Tensions**

Interviewees were asked as to the knowledge, skills, and competencies RHA members contribute to their role within the regionalized governance model. Answers fell within three broad clusters, labeled here as: (a) technical skills, (b) leadership competencies, and (c) community knowledge.

Specific skills referenced by the interviewees included knowledge of business practices, accounting and finance (with 7 of 11 Chairs, 5 of 8 CEOs, and 4 of 8 Ministry interviewees calling on this skill set), knowledge of law and legal practices, and experience with governance and policy monitoring. Only a few interviewees (2 Chairs, 2

CEOs, and 1 Ministry) cited health care knowledge, and one interview (a Chair) specifically commented that RHA members should have no health care experience and should be from outside the system. Given the heavy system-focus to the RHA role and resulting practices (i.e., boards responsible for strategic planning and oversight, alongside performance monitoring and Ministerial liaison), it is intriguing that so few interviewees called on health system knowledge as an asset.

The second domain of skills cited in interviews was general leadership and interpersonal competencies. Examples offered here included broad thinking, intelligence, flexibility, confidence, being a good listener and communicator, personal integrity, and team players who work well with others.

The third cluster of skills fell into a group I have labeled community connections and knowledge. Examples cited here included familiarity and rapport with town council and other formal and informal community leaders, knowledge of who the health region serves, including their expectations and needs, resources available in the community, as well as historical and developing issues.

Most interviewees cited the need for a mix of skills from across the three domains, and indeed, several (5 Chairs, 2 CEOs, 1 Ministry) explicitly commented that a mix was important (i.e., boards should not be comprised of one particular skill and ideally would call on all three).

#### **5.4.1.1 Skills as Contested Grounds**

Although most interviewees commented that they were satisfied with the competencies of the board, some central actors questioned the adequacy of the current mix of skills given the demands and requirements placed on RHA members. One CEO,

for example, specifically cited the absence of time (as opposed to an absence of their skills or knowledge) as a challenge facing RHA members.

I don't know ... whether we'll ever go to a paid board member ... where it your job to be a board member ... and learn about a system and actually truly participate in decision-making. Because the current system ... they are volunteers; they get a per diem ... and yet they have this sense of tremendous responsibility and accountability that often times they don't have any control over ... We talked about community participation ... part of that is board members getting out there, taking more responsibility and engaging the community. But they don't [have the time] because they are volunteers. They don't ... it is a difficult, difficult job. And yet they feel the need to; they feel the responsibility to get out there and talk to different people. If they wanted to be a politician they could run for office, but they are not politicians, and it doesn't carry a lot of remuneration to do this, you know, all that we expect of them. (CEO 5)

Although this CEO was undecided as to whether RHA members should be paid, he/she nonetheless represents the activities of the RHA board member as akin to a job, one that requires deep knowledge about the system in order to “truly participate in decision-making.” Moreover, like a job, he/she experiences RHA board members to “have this sense of tremendous responsibility and accountability” for their roles and functions, but unlike many professional or corporate employees, board members (for unstated reasons) “often times they don't have any control over.” Given that board members are volunteers and do not have the time to fulfill all of the possible roles, this CEO makes the assumption that system needs and knowledge take priority over community participation and connection.

Paradoxically then, while individuals are selected to RHAs, in part because they are connected community members, their RHA membership could then consume their community time, potentially disconnecting them from the very communities and publics they are to know and represent.

In expressing dissatisfaction with the current configuration of skill sets and competencies offered by the boards, one actor explicitly called for more corporate, business skills in lieu of community connections.

I think we would benefit from stronger business sense ... we don't have strong business leaders that you would normally expect to see ... Our board is very community focused and that is a real asset, but I think we could benefit from and we'll probably see some changes when the new board is appointed in the fall... They understand the communities and the differences in terms of the challenges of delivering care in rural and remote. I think, by their nature, a lot of them are pretty grassroots people. So that, you know, that they're not people that have had, you know, big corporate experiences. [We have] small business owners, we have an accountant, but he is in a very small accounting practice. So it's just a just a different mix. (CEO 8).

In recognizing that a community-focused board “is a real asset”, but expressing a preference for “strong business leaders” and “big corporate experience,” this CEO’s statement demonstrates the ways in which residual logics (i.e., those that favour community boards) are simultaneously both present and marginalized. The community focus of the RHA is represented as a logic of the past, and by implication is outdated, since the CEO anticipates that “we’ll probably see some changes when the new board is appointed in the fall.” In contrast, the emergent logic, which is constructed as a “benefit,” calls on corporate experience and not just professional skills; the CEO clearly does not believe that the skills of an accountant who is “a small, business owner” and has “a very small accounting practice” are enough for RHAs to function effectively.

The need for RHAs to have more “corporate experience” was seen by at least one CEO to be the result of the 2001 amendments and district amalgamations in which the organization of the Saskatchewan health care system shifted from community-based to a corporate model of governance. As this CEO commented:

By moving from districts to regions, we went from community-boards, responsible for large organizations, to community-boards in charge of some of the most complex corporations in Saskatchewan. ... We may have some community representation, but their linkages have eroded from community because of their new size and wide geography. (CEO 1)

This CEO recognizes that with increasing region size, the RHAs needed to attend to issues of “some of the most complex and largest corporations in Saskatchewan.” Thus, “community representatives” and “their linkages” to the community have been “eroded” in favour of system-directed issues. To make the regionalized model work, the amendments have undermined some of the benefits of local boards (e.g., local knowledge and connection, representation, etc.), and as a result, one goal of the boards (local representation and connection) is in direct competition with another (system efficiency).

#### **5.4.1.2 Expertise and Expert Boards**

The desire for more “corporate” skills (Chair 4; CEO 1, 5, 8) signals the emergence of a new discursive thread grounded in a corporate model of health care delivery, and fully articulated by some central actors in the call for “expert boards.”

In comparing the board composition of the Health Quality Council, a provincial agency tasked with monitoring and assisting the provincial system to deliver quality health care, a CEO notes the difference in board structure in which the former is composed of community representatives and the latter of “experts.”

[RHAs] require a balance with “expertise.” Compare two boards established in the 2001 reforms. The Health Quality Council was very much an expert board; [it was not] representative of either provider groups or community interests and [was] populated with experts in the area of quality, health research, and similar initiatives. With the RHAs, it was quite the opposite. We did not get lawyers, accountants, corporate governors, private sector, and business people. We got community members, grass-roots people, community-based representation. (CEO 1)

Clearly, this CEO did not believe that RHAs had the requisite balance.

Not all interviewees favored expert boards and one CEO explicitly prioritized community representation, noting that boards need not provide content expertise to the health region as such expertise was to come from staff. From this CEO's perspective, the value of an RHA was its ability to provide community perspective and understanding of community needs and concerns and to reflect these in decision-making processes.

I am not one [who] believes there is any one skill that must be there. You will often see Boards say "we have to get someone who understands finance." ... I think that's a mistake. ... Your content expertise should come from your [staff]. What you want [on the board] is people that get the big picture. People rooted to their communities and who understand those issues, and who have an ability to lift their eyes over the horizon and see the possibilities. So that ability to be grounded in reality and yet imagine what might be. That's the best way I can describe it. I think that's hugely, hugely important. You can always get people that represent specific constituencies or specific skill sets, but I don't think that is the most valuable thing for the board. (CEO 2)

This speaker distinguishes between the content or technical expertise provided by staff of a health region and the "big picture" or visionary role of RHA board members. This CEO clearly valued the work of the staff, but she/he did not see "content expertise" as critical for board members. Board members are instead to be imaginative and creative (i.e., "an ability to lift their eyes over the horizon and see the possibilities"). In this case, "content expertise" refers to the technological knowledge of people formally trained in specific areas. Moreover, it appears that this CEO believes that the technical expertise of staff is somewhat replaceable ("You can always get people that represent specific constituencies or specific skill sets."), as he/she sees formally trained professionals as more readily available and their product is more uniformly produced through their formal education. In contrast, the speaker does not appear to see the experiences of board members, "grounded in reality," as so easily replaceable.

### 5.4.1.3 Theorizing Expertise

Inevitably, when discussing the role of publics in public policy deliberations, one must contend with the subject of “expertise” and discern just whose knowledge and what contribution is sought. Although this tension did not emerge when central actors were discussing the who, what, and how of public participation (section 5.2.3), it became visible during discussions of knowledge contributions.

Evans (2008) reviews some of the seminal tensions in the theorization of “expertise” and the varying types of expertise at play when publics participate in policy and science-based deliberations. Arguing the need to maintain a boundary between experts and non-experts, but to nuance their conceptualizations, Evans highlighted tensions between, *inter alia*, contributions of subject-matter experts (e.g., facts, accuracy, and an understanding of the technical content that then contributes to scientific debate) and lay-citizens (e.g., values, political legitimacy, and contributions to democratic debate), and between specialists (with deep and focused content knowledge) and generalists (with shallower and broader knowledge). The necessary contributions will depend on the situation and the nature of the issue under review (e.g., does the policy issue debate require more scientific understanding or more democratic support).

Collins and Evans (2002), in positing the need for a “science of expertise and experience,” detailed these tensions and the problems that they see arise when the scale is tipped too far to one side or the other. For Collins and Evans, problems of legitimacy erupt when the scale is tipped too far towards formal expertise and the democratic contributions of publics are excluded from policy deliberations and decisions. Conversely, problems of over extension of publics can occur when the scale is tipped too

far towards democratic participants, away from necessary contributions of technical or scientific expertise from public policy deliberations and decisions.

These tensions became visible within the current research when interviewees pit technical skills and expertise against community knowledge and connection. For some interviewees (e.g., CEO 1 and 8), the contributions of professionals with corporate expertise were needed to rebalance the scale whereas for others (e.g., CEO 2), the scale needed to favour generalists and non-experts who could offer fresh eyes and creative ideas.

Within discussions of knowledge contributions, an interpretation that contributes to the tension appears in a commonly offered comment on a “complexity” of the system.

#### **5.4.1.4 The Health Care System Is Complex**

Whether or not interviewees called directly for more professional or expert boards, all interviewees were united in their belief in the complexity of the health care system generally, and the RHA governance domain specifically. The health care system was described consistently as “very complex” and “complicated” (Chair 1, 2, 6, 10, 11; CEO, 1, 3-6; Ministry 2, 3), one that “the average citizen cannot grasp” (Chair 2). This perception was cited as a limiting factor for community boards.

[The RHAs] need all the help that you can give them to grasp the complexity. (Chair 6)

So, you have to be a little bit understanding of giving them time to digest and understand. Some of these issues can be pretty complex. (CEO 6)

I would suggest that health care is a very complex system and ... I would say it's very difficult for a layperson ... to be appointed to the Board and say “I know everything [and can contribute to] strategic planning and charting a course for the region. I know what way we should go.” And I think, by and large, that well-intentioned people with a lot of life experience, they struggle. They struggle to understand the day-to-day and just the lingo and terminology. It takes a long time for them to understand



the topics, the issues behind the issues, never mind, you know, “where should we go and how do we get there?” (CEO 5)

We have the complexity of these corporations that requires a balance with “the expert’.” (CEO 1)

From these quotations, it is clear that the complexity thread of this discourse is tied directly to the perceived need for “expertise.” Board members are referred to as “laypersons,” needing “all the help that they can get;” they are “well-intentioned people with a lot of life experience from different sectors,” but they oversee a complex system, and therefore the views of the laity “[require] a balance with ‘the expert’.” Clearly, in the eyes of these CEOs who are responsible for managerial oversight, current board members who come from the lifeworlds lack the requisite skills to run the health care system as if it were a corporation.

Not all of the central actors believed that the health system was “complex,” and required experts to oversee and govern it, noting that agendas and board materials can accommodate lay-skill sets.

Well, there is a question, whether or not you're looking for lay-boards or some sort of expert panels. Some think you have to have experts on these things. Why? I mean, if the information that is presented to the board is legible and understandable, than most people can make these decisions. I think part of it in health care, is that people are trying to make these things much more complicated than what they are. (Ministry 5)

This Ministry official demonstrates respect for individuals who may not be experts, but are nonetheless smart enough to understand the information presented for board consideration. Of course, comprehension is dependent upon experts presenting information that “is legible and understandable,” implying that “expert language” can contribute to obfuscation.

It would appear that differently situated people would solve the complexity issue in different ways. Some interviewees favour more specialists and expertise while others favour the contributions of generalists and people who can “lift their eyes over the horizon and see the possibilities” (CEO 2).

Expert and lifeworld knowledge were translated by some CEOs into a distinction between “the facts” and “a community story” in which “facts” took precedence over a community “story,” and “the facts” were to be conveyed back to the community.

But I find that [the RHAs] are very reasonable and will, [if] facts are there that are different from what they are hearing at the community level, then they will listen to that. Then the discussion is around “then how do we convey this message back to the community?” (CEO 3)

But, you know, we are just describing more or less the staffing that we had and the nursing aspect of home care, and one community of a similar size has a little less, so then come the protection questions [from board members]. But, you know, that’s good because then they think about it when they leave the building. And I’d rather have them ask the question and then we can respond and say you know “Well, you know, here’s the stats; here the demands a bit higher.” (CEO 4)

Occasionally, you get a board member who brings an issue to the table, making a statement or a generalization about what we’ve done and you ... you know they don’t have all the facts. They have got part of the story and not the whole story and so sometimes, you know, ... you’ve got to smooth the waters. You’ve got to come back with the facts and ... (CEO 3)

Clearly, what is “reasonable” is for a board member to heed “the facts” and “stats;” board members are prone to “making a statement or a generalization” and “they don’t have all the facts.” In the view of these CEOs, board members have only “part of the story,” one that is rooted in the lifeworlds of board members. For these CEOs, “the facts” and “stats” make up “the whole story” in which particular types of information (i.e., facts, the statistics, the administrative story) can take precedence over other types (e.g., community stories and the view from lifeworlds). Moreover, conflicting stories pose a

public relations challenge for the CEOs “how do we convey this message back to the community?” and “you have to smooth the waters.” Conflict resolution requires careful negotiation between Chairs, CEOs and the RHAs, as this Chair observes, in order to preserve the balance of power that favours administration.

I have to admit I have to be careful not to make too many comments until I've spoken with administration about it, because I have to make sure I get the story straight. (Chair 10)

Clearly, this Chair needs to “get the story straight” and feels constrained to speak until she/he is able to speak with administration, thus illustrating the Chair’s subordinate position vis-à-vis administration while providing insight into the ways in which the influence of the lifeworld maybe circumscribed.

This pro-administration, pro-fact bias was not unanimous, however, and as demonstrated in the following quote, community board members helped management teams consider community perspectives in their decision-making. From one CEO’s report, community presence and external perspective could balance the more insular, system-focused, abstracted views (of numbers and balanced books) of staff.

I mean it’s probably very easy to be insular and just focus on the providers, the programs, and our patients, and I think the board brings community perspective, because really, if, and I have a concrete example, if it was left to the senior management team, we would have closed several rural facilities by now. We would have balanced the books, because it would be about the health system, not the health system within the community. (CEO 7)

This speaker postulates that senior management, in isolation from communities and making decisions primarily within technocratic logics, would produce different outcomes (in this case facility closures); “balancing the books” would be the overriding concern. In this way, the presence of community members on boards may have made positive contributions, serving as a defensive dam to technocratic logics (Habermas, 1987a).

#### **5.4.1.5 Summary:**

This research has captured the emergence of a new phase to the technocratic rationality being constructed through regionalization, one that may further displace democratic logics by challenging the very concept of “community-minded” boards. The belief in a complex system and problems coupled with the call for “expert” boards by some of the actors signals a further shift to a focus on technical issues of system performance and corporate business practices, a move that may put distance boards from the communities that they are to represent precisely because “community” members do not have the requisite knowledge. The privileging of expert knowledge over knowledge of the local leaves less room for articulations and practices of community representation and participation, thereby weakening democratic logics. At the same time, the establishment of expert boards (re)asserts a boundary between communities and experts, and repositions health system governance as an elite activity. These boundaries are further entrenched with expectations that RHAs prioritize “regional over local” positions.

#### **5.4.2 Technocratic – Democratic Tensions: “Think Regionally, Not Locally”**

The amalgamation of 32 district health boards into 12 regional health boards in 2001 created a new super-ordinate, geopolitical space “the region,” whose priorities took precedence over other geopolitical spaces community (in this case, smaller communities within the larger region). “The region” was constructed as an administrative structure whose goal was to achieve “the maximum benefit for all residents” or the common good. RHA members were therefore to “think regionally, not locally”-- a statement repeated throughout interviews (i.e., 8 Chairs, 6 CEOs and 3 Ministry interviews cited this phrase).

From the point of the view of the central actors, “thinking regionally” was a more appropriate model of governance because it released RHAs from being obligated to local interests. Thinking regionally “made the job easier” since RHA board members were less likely to be mired in the lifeworlds of citizens; that is, board members were abstracted from the material lives of citizens living in the region. Instead, “thinking regionally” allowed RHAs to think about “the whole more often.”

And the thinking that goes on, being human beings after all is that, what can happen and probably does, is that you become obliged, I think, if you’re elected, to serve the needs of just your ward. And, you might want to consider the whole more often and yet you might be tied to a ward. Regardless of whether you want to be elected again or not, there are those obligations. Whereas as a trustee of the RHA, if you happen to come from [a community] ... you might feel some obligation to those citizens, but if you don’t come from there, it makes your job easier, I think, if you have no connection, other than to the entire region and the citizens of the entire region. In fact then, that allows you to think regionally, provincially and it makes the job a lot easier. (Chair 2)

The expectation that RHAs prioritize the regional over the local was referenced in many interviews as a competency, one that would prohibit a “narrow, parochial focus” (CEO 2), prevent “turf protection” (Ministry 5), and preclude the possibility of members defending one community at the expense of another and the larger region. In some cases, local interests were not only displaced, but also disparaged, as one Chair (Chair 11) urged board members to “leave their baggage at the door.” As a result, RHA board members were urged to set aside “the interests of a particular community,” to have “no agenda,” and “to leave their baggage at the door.” That is, RHA board members were asked to don “the veil of ignorance,” a concept developed by Rawls (1972), who argued that individuals should transcend their particular interests or differences for the common good. In Rawls’ view, equality could be achieved if all people were viewed, and therefore, treated as the same—despite their differences. However, as it became clear

from the interviews, some individual RHA board members, as well as RHAs, found it difficult to relinquish their ties to communities and “think regionally.”

The establishment of “the region” not only displaced local community interests, but a new logic can also be detected in the language of “thinking regionally,” one grounded in a business model.

But the boards, as much as they're supposed to represent their communities, have to represent the best interest of the region, and the corporation. And that may sound legalistic, but part of it is true, is that these boards aren't there to protect the interests of a particular community -- whether it's protect their ambulance or their public health nurse or whatever -- they're there to ensure the maximum benefit for all residents ... We really don't want them out there simply turf protecting. You really want them to be looking at the broader corporate interests. (Ministry 5)

Despite the ambiguity of the boards' representation of communities (“they’re supposed to represent communities,” but “they aren’t there to protect the interests of a particular community”), this Ministry official clearly believes that the regional perspective trumps the local. At the same time, the Ministry official introduces another entity—the corporation—which is not tied to a geopolitical space, and is distinct from the region (denoted by the “and” joining “the region and the corporation”).

#### **5.4.2.1 Representation versus Local Input**

A key issue, as the following quote indicates, was “who did the RHA board members represent?”

[W]hen we started out [with the district boards] ... we had people coming in [saying] “I represent here,” and “I represent here,” and “I represent over here” .... It took us probably three years to get most of that wiped out on the district board, where we got people thinking, “Look, we’re looking after the whole district, we’re not looking after this town or this RM. We’re looking after the whole thing.” And then, when we had the big switch to regions, well then we were three old districts formed into a region, and we had to do it all over again. Because everybody said, “well, I’m looking after what used to be my district.” Not the way to go, and we’ve completely eliminated that. In fact, I even stressed it very strong

with the CEO and the VPs, “you guys don’t talk about what used to be [district X], or [district Y], or [district Z]. We don’t want even want to hear about that. We talk about [the region], and that’s it.” [It’s] very important, very important. (Chair 5)

As is evident in this Chair’s statement, RHAs represented nobody (i.e., particular communities ) and everybody (i.e., the region) simultaneously. In the previous incarnation of the boards, board members clearly felt that their role was to represent the positions of local communities, as evidenced by the repetition of the phrase “I represent here.” The challenge for this Chair, at least, was to eliminate this type of thinking in favour of the region, “the whole thing,” which ultimately, is an abstraction of the highest order that was realized as the organization of health services moved from many boards governing specific facilities, to district health boards, and finally, to “the region.”

The process of initiating regional thinking was obviously frustrating for this Chair, and the reasons that board members had difficulty in adapting to thinking regionally rested on their ties to local communities. In the first instance, the ability to “think regionally, not locally” was challenging for board members who had been elected under the 1992 model and who were accountable to the electorate--“their own individual community interest.” Under the new model of regionalization, these board members were asked to transcend the local and think about “the whole.” However, the transition from the 1992 to 2001 model was left difficult for board members who had been appointed since they remained accountable to the Minister all along.

Now it's important to note that we try to be very clear ... that [RHA members] are not to represent their own individual community interest but rather they're there to represent the interests of the whole, of the entire Region. In Districts with the partial election, partial appointment, it was a little more difficult to achieve. In Regions ... there was quite a shift ... in district days, when you were elected, it was quite clear who you were accountable to ... the people who had elected you. For those appointed [to

districts], and [RHAs] it's quite clear who you're accountable to, and that is the Minister and ... ultimately the government of the day. (CEO 1)

The effect of canceling elections and moving to fully appointed boards was helpful not only in securing particular compositions of the board (e.g. skill sets and diversity), but government appointments streamlined and ensured greater accountability to the government and administrative state, and not the electorate. At the same time, it should be noted that the electoral process did not ensure necessarily a diverse representation of community interests since voter turnout for the election of District Health Boards was very low. The main difficulty in achieving the goal of “thinking locally” rested with the appointment process itself. A board member’s appointment is based at least in part on connections to and representations of specific sites and experiences (e.g., geographic and cultural identities), but this particularity was to be dropped once board members were appointed, and they were then expected to adopt the general perspective. Thus, the privileging of regional thinking is based on a fundamental contradiction between the basis of a board member’s appointment and the role that a board member was expected to play once she assumed her position on the RHA. As a result, board members are forced to navigate between community expectations and the demand to think regionally, with this becoming a potential source of conflict between the board member and the community (Ministry 4; Chair 2, 11; CEO 1, 3, 7).

The selection of individuals to a position (either through election or appointment) based at least in part on their representation and tie to a community, but then expecting that they demonstrate no particular tie to it, is not a new tension in democratic theory. Much has been written to argue that suppression of particularity (i.e., local) to the general (i.e., the regional) as a strategy intended to minimize bias, in fact introduces bias (e.g.,



Landes, 1995; McLaughlin, 2003; Mouffe, 2000; Young, 2000). By excluding domains and topics that have resonance with the particular and permitting only those that have resonance with the general, certain topics are prohibited and excluded from the agenda. This forced exclusion can itself create systemic bias. The liberal democratic desire to separate out context and not hear local specifics is driven by a belief that recognition of particulars and specifics contaminates judgment (McLaughlin, 2003: 59); a sentiment heard in the interview data when such situated knowledge is seen as “baggage.” This belief fails to recognize that situated individuals (not abstracted individuals) can be foundational to political life (McLaughlin 2003: 40). One could ask whether this bracketing is possible or beneficial, and whether, if it is possible, it advertently introduces biases rather than eliminating them. While it may be the intention that universals are inclusive and neutral, the reality is that the current model is often far from it (Landes, 1995:98). Moreover, the elimination of the particular in favour of the universal can blur issues and sensitivity to difference (Young, 2000). Difference becomes marginalized, flattened, and homogenized rather than attended to as informative nuance. What is thus sought in the appointment of RHA members is simple representation of identities, not substantive representation of different ideas and positions.

In these ways, the shift to thinking regionally (not locally) resulted in the loss of formal mechanisms for board members to represent their communities; that is, “to act or serve as the spokesperson or advocate of” (Oxford English Dictionary). Nonetheless, local knowledge was seen as a valued resource.

They don't represent their communities but they do bring that knowledge forward and things that might be missed, [like] points of view. (Chair 9)

This Chair is clearly distinguishing between representation in terms of being an advocate and providing local input. In the first situation (advocacy), board members play a proactive role in the representation of local interests; in the second situation (providing input), they are conduits of information that can be considered—if it resonates with regional priorities. If local knowledge and particular contexts are viewed unfavourably (i.e., considered “baggage”), boards may never hear and learn local nuances from their fellow board members. If the practice, however, is that particularities are first heard and understood, and then a regional perspective is considered and encouraged, the nuances of the particular (i.e., the local) can be registered as knowledge and enter into discussions, deliberations and considerations.

#### **5.4.2.2 Summary**

Prioritizing *common* interests over individual and particular interests (in this case expressed as “regional over local”) can resonate with liberal democratic logics that encourage consideration of shared resources and common issues. One of the most poignant examples of the common good is the provision of universal health insurance itself, which was designed to ensure access for all citizens regardless of ability to pay. At the same, the privileging of the regional over local, depending on how practised, can limit the ability of an RHA member to raise local issues and particularities, and much has been written to question just whose interests are heard and prioritized when searching for common interests (e.g., Landes, 1995; McLaughlin, 2003; Mouffe, 2000; Young, 2000).

#### **5.5 Absent Population Health Logics**

Well, if you are going to empower communities, then you have to allow them to make decisions and move forward. (Chair 3)

It can be as informative to consider what is absent from discussions as it is what is present. None of the interviews referenced population health logics, which informed the 1992 announcements of local health boards. The original 1992 announcement texts (Saskatchewan Health 1992a, 1992b, 1992c) were replete with reference to democratic and population health reasons for introducing a regionalized health system with local community boards. Similarly, the Legislative Assembly texts capturing Government announcements and framings of regionalization called heavily on the rhetoric of community control and local empowerment, while interrogations and critiques from the Opposition (the Saskatchewan Party now in power) signaled interest in issues of community control. Furthermore, the NDP Government positioned regionalization within a “wellness model” and an agenda targeting broader determinants of health (as opposed to simply addressing access to medical care). Given their prominence in the original framing documents and their presence in Hansard pronouncements, the absence of population health logics within the interviews is surprising.

Although the 1992 announcements called on population health logics, it does not appear to have been taken up or to have been sustained through the intervening years and operationalization of regionalization. Not only have counter- logics shown up (e.g., the notion of regional concerns taking precedence over local concerns), but recall that some individuals scoffed with the mention of population health goals.

In the same way that the presence of various discursive elements helps to (re)produce it in the present, the absence of various discursive elements helps to marginalize and erase its influence and (re)productive power. Thus, what is *not* being said is equally important to what is being said. It is relevant that none of the central actors

referenced larger international trends clearly linked to the movement (e.g., welfare-state restructuring), and only three interviewees called on health system trends outside of Saskatchewan but within Canada (Chair 1, 2, and CEO 8). Similarly, given the heavy connection of regionalization with ideas of community empowerment and control (at least in the 1992 NDP government pronouncements), and given the academic positioning of regionalization as an avenue to population health gains via local-determination and empowerment, it is significant that no interviewee cited elements of population health logics. That these guiding logics are not reflected in central actors' habitus and have been erased, or were never adopted, influences and constrains the practices that can come after.

## **5.6 Summary**

This chapter detailed the democratic traces, tensions and hybridizations that appeared in central actors' interpretations and practices of regionalization. While their discourses were steeped in technocratic framings, democratic elements persisted. Traces of democratic framings were evident within discussions of the reasons for regionalization and public participation, RHA accountabilities to local communities, and considerations of potential ends and effects of the public policies. In all cases, democratic logics appear to have been readily accommodated within larger technocratic framings. As discussions with actors shifted from broader questions of "why" regionalize and engage publics to explorations of how to do and practise regionalization and public participation policies, technocratic logics prevailed (see Chapter 4). In this way, a slight disjuncture exists between some interpretations of the impetus for the policies (i.e., "the why" of regionalization and public participation) and the practices that eventually resulted in their day-to-day (i.e., "the how" of regionalization and public participation).

In other contexts, democratic traces appear to have blended with technocratic framings and interpretations and practices resulted that readily alternate between the two mentalities. In yet other contexts, the democratic traces appear to create tensions and exert pressure to the dominant framings. Overtime, these traces may disrupt, displace, or be subsumed by heavier technocratic mentalities.

Regardless of where and how frequently democratic elements appeared, compared to the original 1992 introductory texts, discourses calling on community governance and local accountability have waned. As experts came to be sought (in lieu of lifeworlds knowledge and community representatives) and as accountability shifts from local publics to the central Ministry, a new type of regional board has emerged, one local and community in name only. Through the descriptions and practices, a regional board is constructed that is responsible for local oversight (not governance), and formally accountable to the central-administrative state (not local publics and communities); one where difference is flattened, with mantras of “regional over local,” and where attempts are being made to have professional knowledge and experience prioritized. Rather than seeing publics as bodies to whom boards (and the system) are accountable, publics are frequently viewed as bodies to survey, monitor, spy on, and manage; to stay one step ahead of; or to better mitigate crisis and manage “uproar.” And when publics are approached and engaged, they are seen as knowledge and experience contributors, who can help the system better respond to their individual (not collective) needs.

As in the case of the 2001 introductory documents, wherein references to de-centered planning, and community leadership and control were dropped in favour of arguments calling on evidence-based decision-making and centralized planning,

technocratic logics may well have erased interpretations and practices that reflect population health arguments. Although academics and researchers occasionally theorized and argued that regionalization was a route to community empowerment and population health gains, this logic failed to appear within the understandings and practices of regionalization and public participation shared in the interviews.

The broader implications of these morphing and subsuming logics will be further explored in the next chapter.

## **CHAPTER 6: INTERPRETATION, SYNTHESIS AND CONCLUSION**

### **6.1 Introduction**

During the 1992 health reforms, publicly stated intentions for regionalization seeded it and its concomitant agenda of increased public participation with explicitly stated intentions for substantive changes to the health system governance model. Politicians, academics, policy advisors, and government officials positioned regionalization as a means to aid the health system, but also as a formal means to introduce citizens into the health system governance structure. Regionalization was justified with both democratic and population health logics, and was theorized, at least in part, as a means to make the system more reflexive and accountable to empowered and self-directing communities and publics. This shift to include public representatives in health system governance (along side traditional players such as health care providers, system administrators, policy-makers, and governments) opened a new site of interface between publics and the central-administrative state. Herein lay its potential to be a radical reform (Lomas, 1996; Lomas et al., 1997), carrying with it the opportunity to rewrite traditional health system power structures.

As is clear from the formal announcement texts (1992 and 2001), from the surrounding debates of the Legislative Assembly of Saskatchewan, and now from the interpretations and practices of the central actors themselves, these introductory intentions for public policies of regionalization and public participation have morphed, and so too have the intentions and potentials of the newly opened interface. After its 1992 introductions, the government amended its early framings and the regionalization model itself. Shifts in logics were visible when comparing the 1992 announcements to the 2001

amendments; texts and speech once ripe with reference to public engagement, empowerment, and control by local communities now referred to efficient and effective systems, guided by experts and buoyed by public input.

While changes were visible in these more formal texts, it was not known to what degree similar shifts were evident in the interpretations and constructions of central actors tasked with taking the announcements and, from them, constructing tangible, day-to-day practices. The interviews of the present research provide this information and demonstrate that the contemporary interpretations and practices of regionalization and public participation in Saskatchewan's health care system echo the shifts of the 2001 amendments. As announcements came to focus on the efficiency and effectiveness of the system, so too, it would appear, have interpretations and practices of the central actors interviewed in this research. These actors have articulated regionalization into a cohesive set of technocratic practices. Population health logics appear to have been all but erased from their discourses and practices of regionalization and public participation. Democratic traces (as defined in this study) persist, however, and while these traces have been largely blended with or subsumed within an overarching technocratic framework, occasional sites of tension do appear. Depending on the resolution of these tensions, these democratic vestiges could be amplified into new and creative interpretations and practices, or marginalized and subsumed by the dominant framings (Brodie, 2008).

Whether accommodated, displaced or amplified, these interpretations shape the day-to-day practices of board members and actors within the regionalized governance model. As a new site of interface between publics and the central-administrative state and between the everyday lifeworlds of publics and the health care governance system, these



shifts and transformations merit consideration and will be the focus of the present chapter as I return to the three guiding questions that informed this research and consider the implications of findings of Chapters 4 and 5 within these questions.

## **6.2 Effects of “Regionalization” Framings**

A guiding question for this research was how central actors framed and practised “regionalization.” As seen in Chapter 4, with the overarching narrative as to the roles, functions, and day-to-day practices, the RHA has been largely constructed within a mundane, technocratic logic. RHAs do not appear to have been articulated as empowering sites, connecting publics and communities to the governance of their local system and services (although elements of public connection were occasionally seen). Through the interpretations, practices, and discourses of central actors interviewed here, RHAs appear to have been constructed as means to support efficiency and effectiveness goals for the health system. RHAs serve primarily as administrative overseers for the state (e.g., ensuring the state was aware of and informed of local issues, and ensuring provincial priorities were attended to by the region level), as opposed to sites operating on behalf of publics and communities (e.g., ensuring local control and public accountability). The day-to-day practices of the RHAs drew their gazes inward (toward the system, towards policies and procedures, questions of system performance and policy adherence, and service efficiency and effectiveness), and thus simultaneously drew their gaze away from external issues of citizen connection, community engagement, and public accountability.

Although referred to as “governance boards,” this was perhaps more a naming convention than a reflection of their role. Their descriptions indicate that many of the

formal and informal structures and relationships within the regionalized model were practised in ways that mitigate an RHA's authority to direct and steer, and thus govern (Prince, 2001). While RHAs were depicted with responsibility for decisions and actions, this responsibility was clearly to and within the specified directions and permissions of the Ministry (e.g., as established in accountability frameworks, statements from the Ministry as to minimum standards, etc.). Ministerial direction, control and sanction similarly mitigated RHA authority, answerability, and performance. The RHAs were primarily accountable to the Minister and Ministry, not publics and communities.

While an internally focused gaze supports useful agendas, these agendas necessarily and readily prioritize technocratic questions and actions over other agendas (e.g., those that readily encourage consideration of issues such as local accountability and representation, and community control and direction setting). These agendas can sacrifice concerns of public accountability in the interest of technical accuracy. External gazes (i.e., beyond the walls of the region and system) can be truncated; there is less concern for how the organization fits within and contributes to broader communities; instead attention turns to (perhaps equally valid and necessary) goals of efficient and effective regional management and performance (Hart, Raymond & Bradshaw, 2010).

To consider these distinctions, compare the answers received with potential answers. What was heard in these interviews was "We are a governance board. We manage the region while staying out of the weeds. We are accountable to the Minister. We meet. We oversee. We ensure policy adherence." Compare these answers to what might have been heard, had framings been more democratic and had actors replied with suggestions that "We are citizen representatives. We connect and talk with local citizens.

We sit on the board and ensure that its agendas and decisions reflect the issues we are hearing in the communities, and the concerns of local citizens, not simply the agendas dictated to the RHA by the system. We look out and over the walls of the region. We consider how the health region connects with community, not simply how the region integrates and coordinates across internal silos.” Similarly, framings rooted more in population health agendas may have resulted in replies of “We are governors serving on behalf of these communities. We are empowered to make local decisions and engage with local community. We consider how the region connects horizontally to community, and how the region can work with others to address broader determinants of health.”

RHAs could be, *inter alia*, expert advisors focused on efficiency and effectiveness, community focus groups providing input and reactions to the system to help guide planning and decision-making, civic governors focused on community interests and accountabilities, local managers working to attend to the needs and interests of the Minister. In practice, they are all of the above and more, depending on context, but a constant chord throughout the interviews was that of a technocratic narrative.

While the actors interviewed in this research largely framed and practised regionalization within a technocratic logic, democratic traces did continue, resulting in an unresolved tension in occasional interpretations and practices. In particular, democratic elements (possibly residues from the 1992 announcements and rhetoric, possibly residues from other sources) could be heard within more abstracted articulations of why the system was regionalized (see section 5.1.2), and why public participation was important (see section 5.3.2). With roles and accountabilities that tethered them to both the system and the lifeworlds they represented (see section 5.3.1) hybridized articulations of

democratic ends and technocratic practices could be heard within RHA descriptions wherein community members serving on RHAs (and to some extent CANs) were positioned as “eyes and ears” for communities and the system (see section 5.2.2). As well, competing articulations as to the knowledge, skills, and competencies desired in and offered by the boards conveyed competing notions of expert boards that contributed technical knowledge versus lay-boards that contributed knowledge of communities (see section 5.4). In these ways, democratic vestiges can still be seen in the interpretations and practices of some actors at some times. Some actors report ties to their local publics and a sense of accountability to them, and while these actors value the formal knowledge skills of professionals and experts, they clearly still value the community connection and knowledge that local board members can bring to the table and decision-making.

As the legislation and public discourses have embedded RHAs within a dual role, so too have the interpretations and practices of the actors themselves; throughout the interviews, while clearly weighted toward technocratic logics, democratic tendencies persist. While largely accommodated and hybridized, with actors shifting between the two, these occasional sites of contestation contain the potential for disruption. Depending on how the tensions are resolved, democratic vestiges could be amplified into new and creative interpretations and practices, or marginalized and subsumed by the dominant technocratic framing. Future research is needed that attends to how the competing knowledge claims and accountabilities are invoked and privileged, where the tensions are managed, and whether and where they grow to disrupt the dominant or be blended in.

For some readers, a limitation of this study will be its perhaps limited conceptualization of a “democratic logic.” As detailed in Table 2 (see section 2.4) and as

rooted within a Habermasian framework of *deliberative* democracy, democratic logics were visible when central actors uttered phrases that resonated with publics coming together to identify (through discussion) and form (through deliberation) common values, principles, and needs, that then pulse the decisions and actions of the administrative state, enhancing political legitimacy and public accountability. It is recognized that other conceptualizations of democracy could have been used to articulate the democratic logic. For example, democratic logics could have been framed within direct democracy frameworks and the research could then perhaps have sought signs of citizen control (as opposed to elected representative control) over decisions. Alternatively, democratic logics could have been operationalised with notions of representative democracy and the research focus could have sharpened to issues of voting rights and representation through elected officials. These are not the democratic frameworks prioritized within this dissertation. Undoubtedly, alternative conceptualizations of this contested term “democracy” could have produced different findings and future research could consider such alternative framings.

### **6.3 Effects of “Public Participation” Framings**

A second guiding question for the research was how actors framed and practised “public participation.” From the interview data, participation was most often described as the participation of patients, consumers, and stakeholders. Discourses and practices reinforced the idea that public participants were to offer input and opinions on service delivery and options, or that RHA members were to provide forums in which system-rooted actors could test their ideas and identify the limits of support in order that they may better plan, execute, and organize maximally efficient and effective health services.

Rarely did discourses construct public participation in terms of citizens and publics exerting control over decisions affecting local issues, or framing macro-level issues for the system then to put into operation (i.e., as lifeworlds and public spheres using deliberatively reasoned values to then guide political–administrative systems).

In light of how RHAs think of public participation, it is important to consider briefly the differences between patients, consumers, and citizens and what these distinctions might mean for public participation. “Patient” is valid role in health care deliberation and discussion, but it is typically a more passive and apolitical role. “Patients” receive care. As a patient, a person calls on knowledge of illness and treatment and personal health care needs and then, quite passively, receives expert-care; in this formula, socio-political issues (e.g., systemic inequity in access or social determinants of health) are reduced to individualizing questions of care and treatment. Compare this role to “consumers” who actively select (and purchase) care; their power is located in their ability to choose and buy (a power that is not equally distributed across consumers), and is connected to the market and economy. While this position might seem like one of agency, that agency is limited in that they only choose from options already available. This act is not a creative one, but merely an act of choice within a limited set of possibilities. Where patients receive and consumers purchase, “citizens” debate. As citizens, people come together to deliberate and articulate values that then help frame issues for the political-administrative system; a citizen’s power is located in her political rights and her relationship with the state. This role has the potential for true agency; it is not just an act of making a choice from available options, but a creative act that can guide the system, contributing to its very building. Where patient roles prioritize individual

illness and treatment, and consumer roles prioritize individual choice, citizen roles have the potential to extend to broader collective issues of taxes, public funding, global budgets, priorities, and allocations (e.g., health versus education versus social determinants of health); in this dynamic, socio-political issues are potential agenda items.

There is little evidence in the present research interviews that these latter, citizen-based roles were considered within constructions of public participation. Public participation was not constructed in terms of citizens and publics directing and affecting the provision of services from the welfare state, but most often as individual users and consumers of services. Such anti-collective reconstructions resonate with neo-liberal reframings of social-democratic political concerns (e.g., Clarke et al., 2007, Jessop, 2000); reframings that carry with them real and affecting consequences (Brown, 2005) as they reshape and renegotiate relations between publics and states (Rose, 1999).

Although central actors' articulations of public participation occasionally referenced democratic roles, the operationalization and day-to-day practices reduced the actual roles to technocratic practices wherein individual patients or users were asked to call on their wishes and experiences as patients (or patient-consumers) to offer input and advice to system-experts. Clearly, their voice and input is sought and valued. Clearly, people are positioned with roles, responsibilities, and contributions to make. Explicit reference to their role as citizen, however, seems to have waned.

The shift in the construction of "publics" from seats of "empowered communities" to "engaged citizens" to "consulted users" to "satisfied customers" has important implications for the focus and goals of the health care system, and ultimately the redistribution of power. The politics of renaming (Dobrowolsky & Jenson, 2004;

Lister, 2000) is real and affects how public policy is framed and what subjects and interventions are appropriate. In the newly reconfigured regionalization discourses, publics clearly have roles and responsibilities (they are no longer passive recipients of welfare-state services), but these roles have changed to those of a self-reflecting individual, able and willing to provide the state with input on her wants and needs. From the perspective of the administrative state, this knowledge of consumers' needs help guide the system in the necessary task of constructing acceptable public services. This consumer role does not, however, allow publics to be involved in a leading role, defining priorities and problems, and establishing guiding values. There is little reflection in the discourse of the varying abilities of different publics to engage in policy decision-making or the notion that participation rights and abilities are not distributed equally.

As health care is a publicly funded service in Saskatchewan and Canada, accessing health care services is necessarily, in part, a right of citizenship (i.e., not only patient status). In effect, Canadians access services in a hybridized role of patient-citizen. In discussions of public participation, as captured in the interviews of this research, however, this citizenship portion of the role was absent.

Just as a dual role exists for RHAs, so too there is a dual role for public participants and while currently weighted towards technocratic framings, the potential always exists for change and technocratic roles could be disrupted and their technocratic framings innovated into more (or less).

#### **6.4 Implications Beyond the Policy and Practices**

A third guiding question for this project was what the findings suggested, not just for these public policies, but also for the larger socio-cultural worlds within which these



actors and practices are embedded. This study was not intended as a historical reconstruction that would describe what happened, and why, as health system regionalization developed in Saskatchewan. Nor was this study intended as an evaluation of health system regionalization, in and of itself. It was designed as a study of the ways in which public participation was constructed within discourses of health system regionalization, as a site through which to examine and consider the changing interfaces between system and lifeworlds, between public services and citizens, between governments and publics.

Viewed from the social theory of Habermas and related notions of deliberative democracy, decisions to regionalize the system, investing local publics and communities with the authority to make decisions and govern local services, were argued as significant opportunities not only for health policy, but also for the public sphere and democratic society (e.g., Dickinson, 2004; Forest, 2004; MacKinnon, 2006). Community boards were imbued with the potential to engage in communicative rationality, to consider issues of public policy and health system reform, and to form deliberated opinions and a political will that could then steer the administrative state. The state would then have the potential to write democratically constituted laws and acts, a hallmark of Habermasian deliberative democracy (Habermas, 1996a, 1996b). Situated at the interfaces of lifeworlds and the system, RHAs and CANs could usher lifeworld influences to the state (whilst simultaneously facilitating the extensions of system logic into lifeworlds).

Citizen participation within the framework of this social theory is about more than the RHA, the health system, the health needs of the community, or even health; citizen participation is about strengthening civil societies and democracy. Citizenship is a means

of providing opportunities (via discourse and deliberation) to identify and form common values, principles, and needs that then guide the political-administrative state. This Habermasian lens focuses an optimistic eye to the positive potentials of regionalization, public participation, and citizen engagement in governance and decision-making, while creating a normative ideal against which to consider system-lifeworld interfaces.

Applying a Habermasian lens to these research interviews makes the interplay of lifeworlds and systems visible. RHA and CAN members serve as “eyes and ears,” as sensors, aiding the flow of lifeworld information to the system (and vice versa --their dual role means that the influence goes both ways, lifeworlds into system and system out to lifeworlds). The potential for democratic effects are there, even though not often referenced explicitly in the contemporary practices and framings.

The data detailed in Chapters 4 and 5 has shown that the presence of community members on an RHA serves to affect at least some of the health region focus and decision-making. Furthermore, their presence helps to ensure that, to some extent, community interests are considered within the health system agenda, serving as a defensive dam to technocratic logics (Habermas, 1987a). At the same time, the central actors’ articulations of the roles and functions of the boards demonstrated that these sites extended technocratic logics (Habermas, 1987a) and ushered them into lifeworlds and communities through the boards (for example by encouraging board members to “spy” on community and help disseminate system knowledge and views to communities).

While notions of deliberative democracy may have helped root the 1992 reforms with its goals of changing lifeworlds-system interfaces, it was perhaps too ideal a logic. The findings of the present research suggest that it will take more than sheer presence and

representation of communities and publics to affect decision-making and that other players (e.g., health ministry staff, professionals, and elites) exert significant influence. The presence of communities and publics may be necessary for this deliberative and democratic shift but it appears that it is not sufficient. This normative and ideal model failed to account for ways in which the real and effecting needs of the central administrative state (e.g., to ensure political legitimacy) and the pre-existing structures and patterns of relation between systems and lifeworlds would continue to exert pressures that mitigate public power in their newly configured governance role.

These real and effecting structures and patterns of relation are brought into focus with Foucault. Through this lens, the focus is on the real and practised (not the ideal and possible), and with a conceptualization of “governing-mentalities” we can consider changes in the regionalized model of health system governance as innovations in governance and ways of guiding conduct.

Viewed within a Foucaultian framework, concepts such as “the public” and “public participation,” “accountability,” “RHAs” are understood as being constituted through and the outcome of the practices and discourses of the central actors and the network of formal and informal relations in which they exist. These positions and ideas are seemingly “natural” (i.e. they are constructed as “the way things are,” “the nature of the beast,” “the system), invariant, and not subject to change. Although these concepts are constructed, nonetheless, their effects are real and binding in their consequences. Within technocratic logics, the subjectivity of the public is as passive individuals, passengers of the system (not drivers), providing input when and where it is requested by the system and its technocrats (as opposed to when and where the demo demands it).

Public representatives are constructed as active and responsible citizens whose duties include helping the system come to better know the passengers it serves. In keeping with the shifts between the 1992 and 2001 government announcements and surrounding legislative debates, publics primarily participate as responsible patients and families, with individualizing patient, client, and consumer positions being prioritized over collective positions of communities and populations. Technical accuracy appears to take precedence over public accountability and engagement. Technocrats and system experts make decisions, input is provided by reflexive publics, and the ultimate goal would primarily appear to be a well-tuned, efficiently functioning health care system. In these models, the state comes to govern *through* “the people”, not *with* “the people.” (Dean, 1999; Foucault in Dean, 1999; Rose & Miller, 1992).

Given the dominance of technocratic logics, this research has demonstrated the need to interrogate the meaning of these ideas. The technocratic logics are constructed and reconstructed through such ideas as governance, accountability, knowledge and skills, and representations, and in fact, shifted from 1992 to 2001, and as they were practised at the time of this study.

Janice Gross Stein (2001) in *The Cult of Efficiency* noted that the education system in Ontario was judged “efficient.” Her follow-up question was “at what?” and “for whom?” The same questions hold here when considering regionalization and the second-wave models that were described by these central actors as “evolutions” and “natural progressions” of the former models, bringing with them greater efficiencies. The unasked questions remain “efficient at what and for whom?” For what and for who are regional health boards established? When and how are the boards to serve the interests of

the system? Lifeworlds? Clarity on these questions, and conscious, intentioned, designed practices to support these goals, would be beneficial. Without it, we readily drift and fall prey to the “cult of efficiency” that Stein wrote of, where good people, meaning well, lose sight of a bigger picture and do less, but more efficiently, without asking at what and for whom. Given that Canadians value a public health care system and that it can often appear to be the most sacred of our publicly funded goods, it stands to reason that attention to publics and lifeworlds be an integral part of this system. We are not only patients and families to passively receive care, but publics, citizens, and communities, who fund these services and whose values should shape the systems, and to whom the system should orient actions *and* be held accountable.

As a Habermasian lens was at times too ideal, a Foucaultian lens was at times too pessimistic and in this way can obscure optimistic considerations of, *inter alia*, the democratization potentials embedded with regionalization and public participation policies. By asking how public participation and engagement as a community board member enables the system to govern through us, we fail to consider how we, simultaneously, can use the roles to effect change and guide the system (*i.e.*, as per a democratic agenda).

The uncommon theoretical approach used in framing this research, namely the combination of Habermasian and Foucaultian lenses, proved a workable and beneficial combination; although seemingly opposed, in actuality, these theoretical perspectives in nuanced and enriched one another, supporting research, and aiding a dual focus that considered both everyday micro-practices *and* normative concerns for lifeworlds-system interactions. Taken separately, a Foucaultian focus on the micro-practices of

regionalization and public participation runs the risk of blurring the power of a centralized state (a centered power that clearly functioned and exerted influence within the establishment and enactment of regionalization governance models and practices in Saskatchewan), while a Habermasian focus on normative ideals and potentials can blur considerations of actual, lived practices. Using Habermas and Foucault together, as Biebricher (2007) proposed, helped to surpass these limitations and the forced distance between these theoretical frameworks, while extending Biebricher's work and providing a concrete example of the two in use simultaneously.

The combination of lenses allowed me to study both the normative and the real and examine the mutually constitutive relationship between discourse and day-to-day practices. My work provides a case study of the blend and shows that it is practical and useful. Working within the two frameworks allowed me to consider the tension between the centralized state as a seemingly stabilized structure, functioning as an actor, and the state as a network of capillaries of power operating through (and with) central actors and publics. Although the state has power, so too do the other central actors. Their most obvious sites of power rest in their ability to interpret announcements, to fix meanings to terminology, and to construct actual practices. The central state provided the framework, but local actors are not without power and agency as they constructed the daily practices. While government constructions created a role and a space of engagement, the interpretations and agency of actors constructed the day-to-day practices.

#### **6.4.1 Other Implications and Considerations**

Although the literature review (Chapter 2) showed that regionalization had been theorized by academics and researchers as a potential route to community empowerment

and population health gains, and although the early announcements were steeped in part in population health logics, this logic failed to appear within the interpretations and practices shared in the interviews. Regionalization policies were not interpreted and framed (by the central actors interviewed in this study) within arguments of active and engaged communities controlling local services as routes to empowerment and populations health logics. Population health is not a policy goal that emerged, within the discourses and practices of the central actors interviewed herein, as a guiding practice of the RHAs or an explicit aim pursued by decision-makers; rather population health, if discussed at all, was assumed to be the end state that would occur through the successful implementation of technocratic practices<sup>23</sup>. What would the system look like if knowledge of marginalized lives was actively sought and prioritized? What data and reports would get produced and consumed? How might health system goals change? How might governance models change? What day-to-day practices might develop?

Allow me to state explicitly that I am not suggesting that any of these shifts were intentional, active manipulations; they are quite plausibly unintentional and well-meaning. But technocratic agendas are more easily operationalized and put into practice than vague, unscripted, unpractised notions of deliberation and empowerment. Undoubtedly, the structure of the reform itself mitigated potential, but so too does citizen complacency, central actors' democratic illiteracy, and a myriad of other constraining variables and forces. Optimistically, however, even though power and potential has been mitigated, democratic traces and effects continue; they appear weaker and more random than if they were intended and planned for, but they are present and they persist.

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<sup>23</sup> This is not to suggest that population health discourses and practices do not occur within Saskatchewan's health system and some health regions (e.g., Saskatoon and its Public Health Observatory) have targeted resources to both studying and attempting to address issues of and disparities in population health status.

## 6.5 Conclusion

The way that regionalization policies and public participation agendas are framed and articulated affects the way these policies are interpreted and practised. Words and interpretations are not benign; they have the power to construct and enable, to constrain and occlude. If democratic agendas are not articulated, democratic practices are less likely to develop. If technocratic agendas are articulated, technocratic practices are more likely to develop. Restructuring the agenda of boards and the knowledge, skills, and competencies called on could foster more democratic practices and agendas. Conversely, if technocratic expertise is what is coveted in a board, agendas can be structured and skill sets prioritized accordingly. If we want a hybridized version, that too can be accomplished, but with intention.

The task might be to clarify what it is that is wanted and needed in regional health boards, and then to structure, compose, and practise accordingly. Are we searching for political legitimacy that can come via the participation of communities and publics? Are we searching for technical accuracy that can come with the engagement of credentialed professionals? With these two logics, public participation becomes a necessary — but not sufficient — condition for good decision-making.

It is not my intention to suggest that these ideal type logics are without challenge and weakness; they all contain problematic assumptions. Deliberative visions assume that representative citizens, communities, and publics are ready, willing, and able to assume new roles and responsibilities. Research has challenged this assumption (e.g., Chessie, 2009; Lomas, Veenstra & Woods, 1997b; Lewis et al., 2001; Side & Keefe, 2004; Wharf Higgins, 1999). Horizontal views that broaden and extend the gaze of health system



workers, enmeshing and entwining the system with communities, organizations, and public services, carry positive *and* negative potentials (e.g., increased integration, coordination, surveillance, shared resources, reduced independence). The population health logics prevalent in the introductory texts of the 1992 model were rooted in communitarian-like ethics that opened health system governance to public participation and local control (Chessie, 2010). This offered the potential to empower and legitimate reform strategies, but it came at the expense of a considered approach of the limits to community capacities, and by ignoring legitimate and necessary contributions of technical experts. The 2001 amendment text reinserted technical expertise, but at the expense of community and public participation and the legitimacy gains they can offer, and at the expense of potential population health gains rooted in community engagement and empowerment. No singular logic is ideal.

None of the models proposed within Saskatchewan's regionalized health system fuse these varying logics to posit models of public participation that balance technical questions and the contributions of expertise with engagement and empowerment logics of population health determinants, and with considerations of democratic accountability and legitimacy. Rather than erasing roles or pitting citizens against experts, or deliberating technical questions at the expense of democratic or population health agendas, perhaps there is merit to balancing the logics. Complicated configurations could move the practices beyond "either/or" models, to those where people, communities, and health systems benefit from complex logics that support participation rights, accountabilities, and expertise. Such a system might move to accurate and informed, legitimate and accountable, equitable and healthy decision-making and governance models.

Regionalization was ushered in on promises of, inter alia, public engagement, community empowerment, and local accountability. A discourse seemingly used to sell it, convince people of its merit, and help establish it, is now all but absent. Community precedence has been replaced with system goals. Regionalization and public participation is now primarily talked of and practised as a technocratic initiative that prioritizes goals of efficient and effective services. Population health logics have been erased. Traces from earlier agendas of democratic input and engagement are falling from the reform agenda; what once was front and cover is now but a residue. Talk of collective communities and citizens have largely been replaced with reference to individual patients and consumers.

It is alarming that this research uncovered no evidence that the shifts are seen as losses. As long as democratic traces are there, however, and as faint as they may be, they are there to be interpreted, practised, and contested, and thus they contain potential. It is when the traces quietly disappear that potentials are lost. Political rationalities wax and wane, opening and closing interpretive and practice spaces as they do (Brodie, 2008). As regionalization and public participation agendas move from democratic to increasingly technocratic frameworks, practices are adopted that prioritize certain agendas (e.g., inefficiencies) while simultaneously erasing others (e.g., community control). Whether the democratic residues evident in these interviews are enough to hold the space and dam further encroachment of technocratic agenda is a question to ponder. Every day words, interpretations, discourses, and practices morph; elements disappear, and new conceptualizations and practices emerge to fill the space.

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## APPENDIX A: Documents Reviewed for Phase One

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- A sample of Saskatchewan Health Annual Reports 1992-present
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- Government of Saskatchewan. 2006. *Regional Health Services Act 2002 (as amended 2002, 2003, 2004, 2005, and 2006)*. Regina, SK: Queen's Printer.
- A sample of Annual Reports from RHAs (as filed on line with Saskatchewan Health, the health regions themselves, or as filed with the University of Saskatchewan Library)
- Accountability Frameworks (from Ministry of Health to RHAs & an RHA submissions) April 1, 2007 to March 31, 2008.
- Corporate Governance Tools for Saskatchewan RHAs and the Saskatchewan Cancer Agency (March 2007)

- *Debates and Proceedings of the Legislative Assembly of Saskatchewan*, sample from the 21<sup>st</sup> and 25<sup>th</sup> Legislative Assembly
- *Debates and Proceedings of the Legislative Assembly of Saskatchewan*, thorough review of the 22<sup>nd</sup>, 23<sup>rd</sup>, and 24<sup>th</sup> Legislative Assembly (search term “health”)
- *Throne Speeches* opening and proroguing sessions of the 22<sup>nd</sup> to the 25<sup>th</sup> Legislative Assembly of Saskatchewan.

**APPENDIX B: Letter of Invitation**  
**Transforming Health System Governance:  
Iterations and Implications of a Saskatchewan Public Policy**

LETTER OF INVITATION

I am a PhD student in Interdisciplinary Studies at the University of Saskatchewan in Saskatoon. I am interested in studying health system regionalization, and in particular Saskatchewan's models of community governance boards and avenues for public participation. In particular, I am interested in exploring the stated intentions, the practices, and people's experiences and understandings of the boards and public participation venues.

With your consent, I would like to interview you as part of this research. Your participation in this study will involve one interview of about 60 to 90 minutes, during which I would ask and you would respond to a series open-ended questions designed to elicit your responses to the above areas (intentions of regionalization, community governance boards and public participation venues; practices, experiences and understandings).

Interviews will be arranged at a time and place chosen by you--the participant.

If you agree, the interviews would be audio-recorded and transcribed. Tapes and transcripts will be accessible only to my research supervisor and me. If transcription support is used, assistants will sign confidentiality agreements with the researcher.

Participants may withdraw from the study at any time with no penalty to them for withdrawal.

There are no intended benefits or risks associated with this study. It is hoped that this study will help us better understand health system regionalization and public participation initiatives within health system planning and governance.

If you have any questions, or wish to participate, please contact Kelly Chessie by phone: (306) 653-2656 or email: [kec129@mail.usask.ca](mailto:kec129@mail.usask.ca) . You are under no obligation to participate and can simply call for more information to help you in considering your possible participation.



## APPENDIX C: Consent Form

### Transforming Health System Governance: Iterations and Implications of a Saskatchewan Public Policy

#### CONSENT FORM

**Researchers:**

Dr. C. Lesley Biggs, Department of Women's and Gender Studies, University of Saskatchewan, (306) 966-1645

Kelly Chessie, Interdisciplinary Studies, University of Saskatchewan, (306) 653-2656

**Purpose and Procedure:** The purpose of this study is to explore the intentions of and experiences with community governance and public participation initiatives within the Saskatchewan health system. As part of this study, interviews will be conducted with Regional Health Authority (RHA) members, Community Advisory Network (CAN) members, Saskatchewan Health employees, and historical figures will be completed. These interviews will allow the researcher to explore the stated intentions, actual practices, and the understandings and experiences of these governance and public participation initiatives.

Interviews will last approximately 60 to 90 minutes. All interviews will take place at a location chosen by the participant, most likely their place of work or a quiet public place, such as a coffee shop or library seminar room.

**Potential Risks and Benefits:** This study poses no known risks or benefits to participants. Being a part of this study may help to increase our understanding of health system regionalization, community governance models and public participation initiatives.

**Storage of Data:** All information collected for this study, including tapes and transcripts of interviews and contact information, will be stored in a locked filing cabinet by the researcher. All data will be stored at the University of Saskatchewan for a minimum of five years after the study is completed, after which data will be destroyed beyond possible recovery. A third party may be recruited to assist in transcription of audio-tapes. I understand that these individuals will sign confidentiality agreements with the researcher, indicating that they will treat my data as confidential and potentially sensitive. They will store it in a secure fashion while it is in their possession, and will destroy all copies once the original and its completed transcript have been returned to the researcher.

**Confidentiality:** The findings of this study will be used as the basis for a Doctoral thesis, as well as in reports to interested groups, conference presentations or academic journal articles. Your identity and that of your health region will be kept confidential. Although direct quotations from the interview will be reported, potentially identifying information, of yourself, other individuals or particular health regions, will be removed.

**Right to Withdraw:** Your participation is voluntary, and you may withdraw from the study for any reason, at any time, without penalty of any sort. If you do choose to withdraw from

the study, any data you have contributed will be destroyed at your request. As well, you are free to choose to not answer any questions that you are not comfortable with and/or to request that the recording device be turned off at any time, for any portion of the interview.

If you have any questions concerning the study, please feel free to ask at any point; you are also free to contact the researchers at the numbers provided if you have questions at a later time. Please do not hesitate to contact the researchers with any questions about the research.

You can contact either:

Dr. C. Lesley Biggs

Phone: (306) 966-1645

Fax: (306) 966-4599

Email: [lesley.biggs@usask.ca](mailto:lesley.biggs@usask.ca)

Mailing Address: Department of Women's and Gender Studies

10<sup>th</sup> Floor Arts Tower University of Saskatchewan S7N 5A5

Kelly Chessie

Phone: (306) 653-2656

Fax: (306) 966-4599

Email: [kec129@mail.usask.ca](mailto:kec129@mail.usask.ca)

Mailing Address: Interdisciplinary Studies c/o Department of Women's and Gender Studies

10<sup>th</sup> Floor Arts Tower University of Saskatchewan S7N 5A5

The ethics of this research study have been reviewed and approved by the University of Saskatchewan Behavioural Research Ethics Board on (May 27, 2008). Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (306) 966-2084. Out of town participants may call collect.

My signature below indicates that I have read and understood the description provided above; I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. I consent to participate in the study described above, and I understand that I may withdraw consent at any time. A copy of this consent form has been given to me for my records.

---

Name of Participant

---

Date

---

Signature of Participant

---

Signature of Researcher

## APPENDIX D: Interview Guide

### *After consent and opening details*

1. Tell me about yourself and your work with health and health regions
  - *Probes: roles, tenures, training, why interested, etc*
  
2. Describe for me, in as much detail as you can, your understanding of the role and function of the RHAs boards
  - *Probes: barriers, facilitators, knowledge, skills and abilities brought and needed, what makes for good/bad member, why community on board?*
  
3. When (and why and how) do you seek additional contact with “the public”?
  - *Probes: who is public, why public important, barriers, facilitators*
  
4. Would you please describe for me your understanding of the role and function of RHAs as they are to relate to the senior administration of the health region and health region staff or health care providers in general?
  - *Probes: difference in jobs and mandate, barriers, facilitators*
  
5. Describe for me your understanding of the role and function of RHAs as they are to relate to SKHLTH?
  - *Probes: differences in role and mandate, barriers, facilitators*
  
6. If you think across time (pre-1992 to 1992 to 2001 to today), and you think across the actors that we have discussed in this interview (CANs, RHAs, CEOs and health region staff, and the Ministry of Health), and you now think of the concept of “power,” for each of these groups of actors, would you say their power has increased, decreased or stayed the same across time? Let’s begin with the RHAs.
  
7. A. Some people, particularly in the early days of regionalization and the 1992 introduction of DHBs, argued regionalization as a plausible route to democratization and “opening the health system up” to public participation and

input. Would you comment on this plausible goal?

- *Probes: Ever heard it? Agree with it?*

B. Some people, argued regionalization as a plausible route to community empowerment, community development, public involvement, and in this way a possible route to population health (for example that empowered and engaged communities are healthy communities). Would you comment in this?

- *Probes: Ever heard it? Agree with it?*

8. Share with me, in as much detail as you can, your understanding of why SK regionalized its health system in 1992 and then in 2001.

- *Probes: differences in models and roles, why CANs were introduced*

9. How has your tenure with the board affected you outside of this role?

10. Voluntary completion of demographic tick sheet (next page)

THANK YOU FOR YOUR TIME!

## APPENDIX E: Demographic Sheet

### Sex:

- Female
- Male

### Education (*highest completed*):

- University degree
- College or tech certificate
- High school
- Less than high school
- Other

### Marital status:

- Married/common-law
- Widowed/Divorced/Separated
- Single (never married)

### Dependents:

- 0
- 1 - 2
- 3+

### Annual gross household income

- < \$25,000
- \$25-50,000
- \$51-75,000
- \$75-100,000
- \$100+
- 200+

### Profession:

- Health
- Education
- social services
- trade
- agriculture
- other

### Employment status:

- Full time
- Part time
- Retired
- Self-employed
- Other

### Age:

- <35
- 35-44
- 45-54
- 55-64
- 65+

### Ethnicity:

- Caucasian
- Aboriginal
- other visible minority or ethnic group