

**THE RELATIONSHIP BETWEEN SASKATCHEWAN'S CO-OPERATIVE
COMMUNITY CLINICS AND THE GOVERNMENT OF SASKATCHEWAN:
TOWARD A NEW UNDERSTANDING**

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By

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ABSTRACT

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Supervisor: Dr. Lou Hammond Ketilson

This dissertation is a study of the public policy-making process, the role of ideas and relationships in this process, and their effect on social economy enterprises, in particular co-operatives. It is concerned with a central problem in all social economy organizations today: understanding the impact of public policy on funding, decision-making and strategy. The relationship between Saskatchewan's co-operative Community Clinics and the provincial government is of particular interest. In spite of a seeming congruence between the goals of the Community Clinics and the government, the Clinics have not been allowed to play a significant role in reforming the delivery of health care services in the province.

The dissertation draws on models and concepts from the literatures on business–government relations, public policy and the policy-making process, the role of ideas and ideology in public policy, the social economy and public policy, and government–co-operative relations. A case study of the Community Clinics is elaborated through key informant interviews and supported by examination of primary and secondary literature.

This research shows that the Community Clinics are unique organizations and that a new understanding can be developed if the Clinics are viewed as hybrids – some combination of co-operative, public, and perhaps even private organizations. The ambiguity in the relationship arises at least in part from the differing and conflicting ways that the Community Clinics have been conceptualized by the politicians, government officials, the health regions, and even the Clinics themselves. The research also shows that the dominant idea at play in the health care policy domain in Saskatchewan remains that of private medical practice, with fee-for-service remuneration, and that the conditions necessary for a major policy change with respect to the role of the Community Clinics do not exist.

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“When we began to plan Medicare, we pointed out that it would be in two phases. The first phase would be to remove the financial barrier between those giving the service and those receiving it. The second phase would be to reorganize and revamp the delivery system – and of course, that’s the big item. It’s the big thing we haven’t done yet.”

Former Premier Tommy Douglas, 1982

CHAPTER ONE: INTRODUCTION

1.0 Introduction

This dissertation is a study of the public policy-making process, the role of ideas and ideology in this process, and their combined effect on the relationship between social economy enterprises, particularly co-operatives, and government. It is also concerned with a central problem for all social economy organizations today: the impacts of public policy on funding, decision-making and strategy.

The central focus of this research is the relationship between three of Saskatchewan's co-operative Community Clinics and the provincial Government of Saskatchewan. In spite of a seeming congruence between the goals of the Community Clinics and successive provincial governments, the Clinics have not played a significant role in the reform and restructuring of the delivery of health care services in the province. This study seeks to examine this paradox with specific focus on the following overarching concerns:

- What role do ideas and ideology play in the policy-making process related to the co-operative Community Clinics?
- What accounts for the ambiguity in the relationship between the Clinics and the government?
- Under what conditions can the dominant paradigm in health policy, specifically regarding the co-operative Community Clinics, be changed?

This dissertation draws on models and concepts from the literatures on business-government relations, public policy and the policy-making process, the role of ideas and ideology in public policy, the social economy and public policy, and government-co-operative relations. A case study of the Community Clinics is elaborated through key

informant interviews and supported by examination of primary and secondary literature. A key aim of this dissertation is to explore the application of a framework for understanding co-operative-government relationships.

1.1 The Context of the Study

Saskatchewan's co-operative Community Clinics were established at a pivotal point in the province's history. Many of the province's doctors went on strike in the summer of 1962 when the provincial government implemented legislation to establish publicly administered and funded health care, now known as Medicare. The doctors believed that the people of Saskatchewan should use private insurers and that the provincial government was interfering in the practice of medicine. In response to the impending withdrawal of doctor's services, citizens in 38 communities across the province organized to provide themselves with health care services. They chose to organize as co-operatives, whereby the members exercise democratic control on the basis of one-member, one-vote. Doctors paid by salary or contract, multidisciplinary teams characterize the Community Clinic model, and a health promotion and prevention focus. Five Community Clinics still exist.

Over the years, the opposition of the medical establishment has continued and government has been ambivalent in its support (Lawson and Theriault 1999). Relations with the provincial government have been problematic, despite evidence that the Co-operative Clinics' costs were lower than those of fee-for-service practitioners. Lawson and Theriault (1999) note that the Devine government actually suppressed a survey done by the Department of Health on the Prince Albert and Saskatoon Community Clinics in 1983. A later study found that members were less likely to be hospitalized, had shorter hospital stays and lower prescription drug costs. Clinic physicians were more productive and Clinics implemented

several innovations in health care (Angus and Manga 1990). The first medical social worker in Canadian group practice was employed by the Saskatoon Clinic in the 1960s, and this Clinic introduced its own prescription drug plan in the late 1960s (Lawson and Theriault 1999). It developed a drug formulary for use by its non-profit pharmacy, which lowered costs considerably through competitive tendering and use of generic drugs. In 1975 the provincial government established a province-wide drug plan based on the model developed at the Saskatoon Community Clinic. This was Canada's first and only universal drug plan at that time (Lawson and Theriault 1999). The plan introduced by then Premier Tommy Douglas eventually became a national plan.

In spite of this, the co-operative Community Clinic model has largely been ignored by the provincial government (Lawson and Theriault 1999). After the 1991 re-election of the New Democratic Party, Clinic supporters hoped for greater recognition and support in the government's plan for health reform because of their common co-operative roots. Changes were necessitated by the rising costs of health care and lack of co-ordination among the hundreds of health care providers. The reforms that were implemented involved closure of 52 hospitals and a complete reorganization of the governance of health care provision in the province. Saskatchewan was the first province to undertake this kind of sweeping health care reform (Lawson and Theriault 1999).

The Clinics endorsed the province's plan for health reform because of a seeming congruence of goals, principles and models – and in order to show their willingness to be team players. However, they were disappointed when in 1994, it was announced that the government intended to transfer funding responsibilities for the Clinics to the new district health boards (Lawson and Theriault 1999). Among other concerns, Saskatoon's Community

Clinic especially feared the loss of its political and social action role. The Clinics organized to oppose the transfer. In a brief to the government in November 1994, they requested continued funding to the Clinics directly and that the decision to transfer responsibility be deferred for three years; the Minister of Health promised to review the proposed transfer and committed funding for another year (Lawson and Theriault 1999).

In 1997 the Saskatchewan Community Co-operative Health Federation (the Federation) adopted a set of principles to form the basis of a tripartite agreement with the Department of Health and district health boards (Lawson and Theriault 1999). The Federation was formed by the Community Clinics to represent their interests to the provincial and the federal governments. The principles emphasize Clinic autonomy, continued funding by the province, provision of incremental funding through the district health boards for additional community programming, and co-operation and co-ordination between health boards and Clinics to identify and address health needs in the communities they serve. The Federation met with the Department of Health in April of 1998. It was agreed at that meeting that a committee with representatives of the three parties would be established to fast-track signing of the agreements by the end of June of that year; however, no agreements were signed that year. The Department of Health and the Saskatchewan Association of Health Organizations (the districts' umbrella organization) did not agree to the principles set out by the Federation (Lawson and Theriault 1999).

Subsequently, the provincial government established the Fyke Commission on Medicare in June 2000 (*Caring for Medicare: Sustaining a quality system.* 2001) and the tripartite agreements were put on hold to await the results of the Commission's work. The purpose of this independent commission was to identify challenges to Medicare, outline

potential solutions, and engage the public and health care providers in discussions of new ideas for meeting the challenges. The commission issued a Challenges Paper to stimulate discussion; this report did not discuss governance at all, let alone the co-operative health care model.

A Primary Care Branch was then established within the Department of Health. The department's position on the Clinics was that they should remain independent but establish partnerships with their respective Health Regions. The Primary Care Branch was to address other forms of group practice and physician remuneration but did acquire responsibility for the Community Clinics as well.

The more recent federal Commission on the Future of Health Care in Canada (otherwise known as the Romanow Commission) failed to address the possible role the Community Clinics could play in health care reform, except to say that the Clinics are a good model for the delivery of primary health care. This commission was chaired by Roy Romanow, former NDP Premier of Saskatchewan, so the lack of attention to the potential role of the Community Clinics was particularly notable.

In the meantime, the Clinics have tried to strengthen their relationships with their respective Health Region boards. There have been no new cuts and some modest increases in their global funds, but these are much less than inflationary costs and much less than those given to the district health boards. The Clinics continue to operate and, in some cases, to fill gaps in services that were lost when the province closed health care facilities. The pressures of bringing health care costs under control continue, as do pressures to conform to the new governance model. The Community Clinics are trying to adjust and survive, but their future is uncertain. The government has provided global funding on a year-by-year basis, but appears

to still want the Clinics to fall under the jurisdiction of the Health Region boards. Partnership agreements have been or are being developed between individual Clinics and their respective Health Regions. The provincial government also reduced the number of health districts from 32 to 12 Health Regions with new legislation proclaimed on August 1, 2002, ostensibly to further reduce duplication and improve province-wide planning and delivery of service (*An Act respecting Regional Health Services*, Chapter R-8.2 of The Statutes of Saskatchewan, 2002). Most recently, the provincial and federal governments have undertaken a new joint awareness campaign to help the public understand what “primary care” means. This is a component of primary health care reform, and corresponds to the second part of Premier Tommy Douglas’s original plan.

The Primary Care Branch now requires the Clinics to enter into service agreements with the Department of Health (Transcripts 16, 28). These began as one-year agreements but have recently become three-year agreements. The latter are intended to provide the Clinics with a measure of financial stability and to indicate to them that they have the support of the government. However, the Clinics are now also required to apply to retain any surplus they achieve and demonstrate that they will make appropriate use of government funding in their delivery of primary health care services. In addition, they must also receive permission to use any previous years’ surplus retained from previous funding from the department (Transcript 1).

1.2 Theory and Methodology

Examining the policy-making process and the dominant ideas at play is critical to an understanding of the relationship between the Community Clinics and the government. The

provincial government exercises power and control over the Community Clinics through the policy environment it has established. The literature on public policy theory and the policy-making process (Bardach 2009; Doern and Phidd 1992; Stanbury 1993; Pal 1989), and the literature on the role of ideas and ideology in policy-making (Hall 1993; Howlett and Ramesh 2003; Scogstad 2000) inform an understanding of how the Community Clinics have fared in terms of the policies of the Government of Saskatchewan regarding health care delivery.

The theoretical approach used in this study is also informed by the literature on the relationship between governments and co-operatives in general, the role of co-operatives in society, the role of the social economy in Canada, and business-government relations. A framework for understanding the latter is utilized to organize the findings of this research and modifications are proposed to ensure its applicability to social economy organizations, and specifically the Community Clinics. Hoyt (1989) identifies a continuum of government orientations towards co-operatives ranging from outright hostility to controlling. This typology helps to further elucidate the kinds of orientations that have existed in the relationship between successive provincial governments and the Community Clinics.

A case study method has been adopted to gather the primary data for this research. Interviews with key informants were conducted to solicit their views, observations and understandings of the relationship between the Community Clinics and the provincial government. Findings from the transcripts were organized and analyzed through the use of Qualitative Data Analysis software, and these are assessed against a series of propositions that arise from the literature.

1.3 Potential Contributions and Limitations of the Study

1.3.1 Potential Contributions of the Study

The present study makes a contribution to the literature on co-operative community health clinics and their relationships with various levels of government. Further, the research contributes to the understanding of a relationship that has been little studied in the past, the relationship between the Government of Saskatchewan and the Community Clinics. Much has been written about the birth of Medicare but little has been written about how the co-operative Community Clinics fared subsequently. The documentary resources that exist are primarily non-academic – commissioned histories of the Clinics, a few monographs by Clinic supporters and the Clinics’ own documents. The perspectives gathered from the key informant interviews constitute the creation or documentation of new knowledge including behind the scenes observations, candid judgments, and evidence of the discourse and mythology of events that has been told and re-told but not recorded elsewhere. This thesis addresses an important gap in the literature, though a comprehensive history of the Clinics remains to be written.

1.3.2 Scope and Limitations

There are challenges in doing historical research owing to the limitations of the documentary evidence, which is an important source in this dissertation. The few monographs that exist have been written by people who actively supported the Community Clinics or who were commissioned by the Clinics to prepare organizational histories. The Clinics’ annual reports and other documents such as submissions to various health care commissions have been prepared by people closely involved with, and supportive of, the

Clinics. There is likely a certain measure of self-censorship and of bias reflected in these documents.

My background and experience have no doubt influenced the study, including interpretations of the data. I came to this research with the possibility of adopting one of several standpoints. I was employed as a Senior Policy and Program Development Officer in the Co-operatives Directorate in the Saskatchewan Department of Economic and Co-operative Development from May 1992 to September 1997. At the time of writing, I was employed by the Ministry of Energy and Resources. I have worked for the Government of Saskatchewan in this and other capacities for over 30 years, and was on (unpaid) leave to finish this research. Thus, I have been a government official but worked only briefly at the very beginning of my career in the Department of Health.

In the early part of my PhD studies, I was also a member of the Board of Directors of the Saskatoon Community Clinic, serving from 1998 to 2001. I was not working on the topic of this dissertation during that time but this experience was useful in providing me with insight into the views of the Board with respect to its relationship with the provincial government. I have, in essence, been an “insider” in a Community Clinic. In addition, three members of my graduate advisory committee have served on the Board of Directors of the Saskatoon Clinic in the past, and all are affiliated with the Centre for the Study of Co-operatives at the University of Saskatchewan in some manner.

A third standpoint is obviously that of social scientist and researcher. My experience as both a government official and as a member of a Community Clinic board provided me with a greater understanding of the co-operative organizational form and its application in the provision of a wide variety of economic and social projects. It also facilitated access to some

of the key informants interviewed for the development of the case studies. As a social scientist, I recognize the risk of biased interpretations, which might lead to an uncritical treatment of co-operatives, on the one hand, or of the provincial government's position, on the other. Because I have been an "insider" in both camps, I have endeavoured to maintain an informed, but balanced view of each party to the relationship I have been studying.

The selection of key informants interviewed for the case study may also be an opportunity for the entry of bias. The selection of certain individuals and the exclusion of others might influence the mix of the experiences and perceptions being recorded and analyzed. Moreover, because there are only five existing community health care co-operatives in the province, the pool of potential informants for this research was quite small. There were, for example, a maximum of five Clinic administrators and five chairs of the boards of directors. Although there were other board members who might have been interviewed, the Clinics' boards generally adhere to a board policy of speaking with one voice. Additional key informants were drawn from among former members of the NDP Cabinet, health care consultants, and current and former members and staff of the Clinics.

Each Clinic operates within a Regional Health Authority, each of which has one board chair and one executive administrator, as well as a senior executive in charge of primary care. The number of informants from other relevant organizations, including the provincial government, was also limited. Every attempt was made to ensure that the informants interviewed included both elected and appointed officials.

1.4 Presentation of the Study

This dissertation is presented in five chapters following this introduction. Chapter Two provides the context in which social economy organizations operate in Canada, examines the roles that co-operatives, as social economy organizations, can play in society, and reviews literature on government-co-operative sector relations in Canada. The government's relationship with the Community Clinics since recent health reform initiatives began is also discussed.

Chapter Three provides an overview of the public policy-making and policy analysis processes, and then explores the roles of the social economy, organizations, interest groups and ideas and ideologies in policy-making. The relationship between the co-operative Community Clinics and the government is conceptualized and a framework for analysis presented. Conclusions from the literature and propositions arising from it appear in both Chapters Two and Three.

Chapter Four describes the data collection and analysis methodologies. Chapter Five presents the case studies of the co-operative Community Clinics, and provides information on the services, staffing, budget, mission, membership and programs of each Clinic; the chapter also presents findings from the application of Qualitative Data Analysis software to the transcripts from the key informant interviews.

Chapter Six provides a discussion of the results and juxtaposes the experience of the Community Clinics with the propositions developed in Chapters Two and Three. Chapter Seven concludes this dissertation with conclusions drawn from this study. It reflects on the utility of the framework applied to the case of the Community Clinics, and provides

suggestions for the applications of this research, and recommendations for further study in this area.

CHAPTER TWO: CO-OPERATIVES AND GOVERNMENT IN CANADA

2.0 Introduction

This chapter focuses on ideas that governments hold regarding the roles that social economy organizations, specifically co-operatives, play in society. The first section discusses the roles of the social economy in Canada and then the roles that co-operatives, as social economy organizations, have played in society. The second section examines co-operatives in Saskatchewan and paints a picture of co-operative – government relations over the last 60 years. It then reviews three streams of the literature – one that categorizes co-operative – government relations, one that focuses on the legal structure of co-operatives, and one that focuses on co-operatives and the policy process. In particular, this chapter considers the dominant ideas and paradigms at play by reviewing key factors affecting the participation of co-operatives in the policy-making process, and the policy instruments that have been applied to co-operatives in Canada and Saskatchewan.

2.1 The Social Economy in Canada

In Canada, the ability of governments to provide goods and services was eroded or profoundly changed in the 1990s by the need to address debt and deficits, increased global competition, growing pressures for tax relief and other concessions from the corporate sector, shifting citizen demands and the availability of new information technologies. Governments at all levels undertook extensive program reviews and restructuring, and eliminated many programs and services (Lindquist 1996; MacNeil 1996). Many of the values, political powers, and social relationships that define Canadian society were called into question, including the notion of “public” and its link to government (McBride 2001; Teeple

2000). This realignment has had implications not only for public services, but also citizens, communities and broader civil society. As a result of extensive cutbacks and the ongoing discourse around the need for efficiency, the perception has developed that the traditional roles and responsibilities of governments are unable to meet the pressing challenges facing society (Jessop 2002).

The growing body of literature on the social economy shows that there are many interpretations of what the category actually includes and how it is defined. The use of the term “social economy” is relatively new, while the organizational forms it takes have long existed. Bouchard, Ferraton and Michaud (2008) propose a definition based on five principles:

...1) objective of service to the members and the community rather than of profit; 2) management autonomy (the primary element distinguishing it from the public sector; 3) democratic decision-making process; 4) primacy of persons and of work in the distribution of revenues and surpluses...with the addition of a fifth principle: that of participation, empowerment, and responsibility (Bouchard, Ferraton and Michaud 2008).

Social economy organizations are further characterized as follows:

...organization of economic activity; non-capitalist rules of distribution and accumulation; legal and decisional autonomy; democratic powers of users or their representatives. The choice of emphasis is likely due to different ideas of the social economy’s contribution: as a producer of goods and services; as an alternative and sustainable form of development; as an organization of the civil society; as a means of social and economic democratization (Bouchard, Ferraton and Michaud 2008).

People in the social economy have developed a wide range of responses to the withdrawal of governments from the provision of many programs and services. For instance, in Quebec social economy initiatives have developed early childhood day care centres, home care services, and social housing; in Saskatchewan, the co-operative Community Clinics have provided health care services for over forty years; and in New Brunswick, social economy

initiatives have been emerging in connection with the environmental, women's and social justice movements (Vaillancourt and Tremblay 2002).

Levesque and Mendell (2004) note that the social economy has developed in two main areas:

...as a strategy to combat poverty and social and occupational exclusion — initiatives in response to urgent social needs and critical social situations; and in the creation of new wealth—initiatives in response not only to needs but to opportunities in which neither the market nor the state are effectively engaged (Levesque and Mendell 2004: 5).

Social economy organizations have also been important sites of social innovation to address social and economic challenges (Goldenberg et al. 2009; Bouchard 2009). In her review of the literature on social innovation, Bouchard (2009) notes that social innovations are a collective process of invention and diffusion, and that they result in new ways of managing and organizing work, and new methods of performing it. Goldenberg et al. (2009) has found that social innovation has come to be regarded as “legitimate public policy in both the economic and social arenas”. Further, social innovation can:

...bring about transformative change if it is implemented successfully. At the highest level, the goal of social innovation is to address the social challenges the world faces through innovative means. These challenges can be as large-scale as fighting global climate change and reducing poverty or as small-scale as creating a community garden (Goldenberg et al. 2009: iv).

Although the social economy has long existed, it received more attention from governments in response to challenges they have faced during and since the 1980s. For instance, the challenges that the federal government in Canada faced in the 1980s and 1990s led it to consider alternate means of delivering programs and services as part of its restructuring efforts. The intent was not only to improve efficiency but also service to the public. To try to ensure that the co-operative model was considered as a mechanism, in 1996

the Canadian Co-operative Association, the Conseil de la Co-opération, and the Institute of Public Administration of Canada partnered to undertake the Co-operative Alternatives for Public Services (CAPS) project. In spite of the advantages that the co-operative model would have offered in terms of improving responsiveness, performance and accountability, as well as innovation, cost efficiency and local empowerment (Restakis and Lindquist 2001), the ASD/CAPS project appears to have ended without significant uptake by government (Restakis 2005). Restakis and Lindquist (2001) found that the biggest barriers to advancing the project were the large gaps in knowledge of the co-operative model. This was true of governments at all levels, which appeared not to appreciate and how this model might fit into plans to restructure service delivery.

It appears that governments have subsequently become interested in the social economy to address gaps in programs and services that need to be filled, but recognition of and support for social economy organizations by governments has varied according to political ideology.

Interest by governments in the social economy was evident through federal initiatives and corresponding provincial involvement. For instance, by 2000, the Liberal government of the day had already begun to strengthen the relationship between the federal government and the voluntary sector, which culminated in the establishment of the Voluntary Sector Initiative (Government of Canada. Voluntary Sector Initiative web site). Former Premier Lorne Calvert of Saskatchewan, leading an NDP minority government, mirrored this initiative by establishing the Premier's Voluntary Sector Initiative in recognition of the contribution of voluntary sector activities to the quality of life in Saskatchewan.

However, the interest of governments in the social economy was not always benign. Browne and Welch (2002), for instance, provide a critique of how social economy organizations providing health and welfare services in Ontario were affected by the Harris government:

Federal cuts in social expenditures and provincial policies of fiscal restraint and privatization have had a serious impact on Ontario. The neo-liberal right — both the Conservative Party at the provincial level and the Reform Party/Alliance at the federal level — has drawn some of its popularity from people's disenchantment with government. Of course, it did not respond to this disenchantment by promoting greater democracy in the delivery of services through the social economy; it extolled the market and consumerism. Thus, the neo-liberal response to the critique of the state is the privatization and commercialization of services. With the Conservative government of Mike Harris, all progressive social forces have had their backs against the wall and have suffered major setbacks. Consequently, there is today hardly any coherent or explicit movement left to build a new progressive social economy in Ontario. On the contrary, in the fields of health and welfare the non-profit sector in Ontario lives in the shadow of privatization and commercialization, that is, in the shadow of the market (Browne and Welch 2002: 105).

Changes in the governing party also affected governments' interest in and support for the social economy. Federal activity included a National Roundtable on the Social Economy (Human Resources and Social Development Canada website) and the Policy Research Initiative launched a project on "New Approaches for Addressing Poverty and Exclusion" (Policy Research Initiative 2005). The social economy was examined as part of this project. In November 2005, the Social Sciences and Humanities Research Council of Canada (SSHRC) awarded \$9 million to fund a suite of projects to link university researchers with social economy organizations (Social Sciences and Humanities Research Council of Canada web site).

When Stephen Harper's Conservatives came to power in January 2006, the social economy initiatives of the federal government were cancelled or scaled back considerably,

along with other social policy and development initiatives focusing on the voluntary sector. The public policy environment for these initiatives changed; where lobby and advocacy groups previously had access to the policy-making process, the new government instead focused on service provision to individuals, thus limiting groups' ability to influence policy decisions.

Critics have noted that the promotion of the social economy by governments may mean leaving governments unchanged and off the hook with respect to social programs and services because they are shifting responsibility to non-governmental organizations without providing the resources necessary to provide good programs and services (Armstrong 2004; Rekart 1993). The social economy could thus become a scapegoat for government.

Dependence on government funding may also force social economy organizations to drop their advocacy roles, diminishing both their autonomy and their democratic nature. Further, workers in the social economy are generally paid lower salaries than government workers so shifting program and service delivery to them could allow governments to achieve cost savings (Browne and Welch 2002). Finally, moving programs and services out of public administration could leave them subject to trade liberalization agreements and organizations (Armstrong 2004).

These criticisms of government behaviour with respect to social economy organizations provide important context for the study of social economy organizations such as co-operatives. These organizations are products of their social, economic, political and cultural environments and histories. While there can be productive partnerships between governments and social economy organizations, the stated and unstated objectives of governments for supporting social economy initiatives must be considered. It should also be

noted that not all parts of a government are necessarily united, and that governments are not necessarily coherent and strategic with respect to their objectives toward social economy organizations.

In summary, the literature suggests that governments' support for and recognition of the social economy varies according to political ideology, and that the views and goals of the government and those involved in the social economy can differ and conflict. Governments tend to view social economy organizations as able to fill gaps in program and service delivery, while reducing related costs. Founders of and practitioners in the social economy tend to view these organizations as vehicles to serve the needs of under- or ill-served groups and to develop innovative solutions to service and program gaps.

2.2 The Roles of Co-operatives in Society

Governments hold varying ideas with respect to the roles of co-operatives in society; governments can and have used co-operatives as policy instruments in a number of different ways according to their political vision. Indeed, co-operatives have been used to achieve both benign and less benign objectives (Fairbairn 2000; Hoyt 1989; Craig 1993). Fairbairn notes that:

In the international context, co-operatives have been favoured because they improve national economies; assist primary producers (especially in agriculture), particularly to market exports; reduce unemployment by creating locally-based jobs; reduce dependency on the state; and provide services to rural areas that investor-oriented firms are less interested in serving, among other reasons (Fairbairn 2000: 49).

On the other hand, governments have used the co-operative model to exert control over certain groups of people. Craig (1993) notes that the establishment of co-operatives

under some neocolonial administrations primarily served the interests of the state and its favoured subgroups, and did not promote equitable grassroots development:

Co-operatives values and ideology are strongly egalitarian and opposed to racism. Yet agricultural co-operatives were well developed by white farmers in South Africa during the apartheid era and most Afrikaner farmers are members and supporters. The white-only leadership was silent on the issue of apartheid and exclusion of blacks occurred in the co-operatives as well as elsewhere in white society (Craig 1993: 190).

As a further illustration, in some countries co-operatives must conform to state plans, ownership cannot be traced to individuals, and benefits are not distributed on the basis of patronage – all of which violate fundamental co-operative principles (Hoyt 1989). The strong role of co-operatives in centrally planned economies has created controversy in the international co-operative community as to what constitutes a co-operative (Hoyt 1989: 82). There is also debate about the appropriate role of government in developing economies, where co-operatives are often used as a tool to augment development. Development assistance flows from the developed countries' governments and their co-operative organizations to assist in developing co-operatives in the Third World (Develtere 1992).

Develtere (1992) describes how the imposition of the co-operative model by colonial regimes was aimed at incorporating “rural economies into the world capitalist system”. Co-operatives ensured that colonial merchant-traders could obtain sufficient goods to meet growing demands from their home countries, but primarily for their own benefit, not that of the co-operatives' members. While co-operatives are in theory voluntary and open organizations, in practice co-operative sectors in developing countries have to a large degree been externally driven, as have the institutional arrangements in which co-operatives are supposed to function (Develtere 1992). Outside agents, primarily governments' were

frequently responsible for implementing the co-operative model in colonized countries. However, co-operative movements in the home countries were also involved in promoting and establishing co-operatives in the colonies. Doing so was viewed by these external agents as essential for maintaining social control, although this was not the stated purpose. As Develtere (1992) notes:

The promotion of co-operatives was directly linked to the unrest that was growing in many places in the Empire. The British authorities, in many cases, introduced co-operative schemes only after rural or working-class protest (Develtere 1992: 39).

Governments' treatment of co-operatives in other countries is discussed further in Chapter Three.

The roles of co-operatives in more affluent and developed countries have been somewhat different from their roles in the colonial South. Torgerson et al. (1998) discuss the main approaches to agricultural co-operative development adopted in the United States — the California School and the Competitive Yardstick School — that are described as particularly and distinctly American. They claim that it is this distinctiveness that resulted in particular policy roles for co-operatives.

According to Torgerson et al. (1998), the California School, initiated by Aaron Sapiro, was developed in response to the need of agricultural producers to ensure they received fair treatment and obtained improved control and co-ordination of marketing procedures. They did so by establishing co-operatives to market specific agricultural commodities. These co-operatives took the form of direct membership associations with long-term membership contracts and professional management. The lack of professional management was deemed to have been a major cause of co-operative failure in early co-operative marketing efforts. Through improved management, growers were able to avoid the

“disastrous consequences” of having their crop dumped on the market at the same time, driving the price down.

Sapiro is credited by Torgerson et al. (1998) with creating awareness throughout North America of the potential for farmers to organize to improve the terms and conditions under which they did business. The advocates of the California School are also credited with playing a major role in the passage of the Capper-Volstead Act of 1922 (Capper-Volstead Act of 1922. Approved, February 18, 1922. (42 Stat. 388) 7 U.S.C.A., 291-192) and the Cooperative Marketing Act of 1926 (Cooperative Marketing Act of 1926 (July 2, 1926, ch. 725, subchapter 2, 44 Stat. 802)). These same advocates influenced the creation of orderly marketing mechanisms under the Agricultural Marketing Agreement Act of 1937 (Agricultural Marketing Agreement Act of 1937. 7 U.S.C. subchapter 601).

E.G. Nourse (1927), a Chicago school economist, advocated a different model of co-operative development to counter the broader scheme of Sapiro. Rather than direct membership co-operatives that tended to be organized on a regional basis, Nourse’s Competitive Yardstick School advocated smaller, locally controlled co-operatives focused on providing the services that farmers needed in their communities. A main difference was that he believed that co-operatives “could be organized to represent a limited share of marketing activity and still serve a yardstick role by which members could measure the performance of other firms dominating the marketing channel” (Torgerson et al. 1998: 3). By their presence, co-operatives could play a check and balance function in the market. They would increase competition to the ultimate benefit of farmer-members. Nourse disagreed with Sapiro’s idea of democratically-controlled and market-dominant commodity co-operatives and instead advocated that co-operatives could “attain scale economies by affiliating through purchasing

or marketing federations that preserved a bottom-up structure rather than a more centralized, top-down one” (Torgerson et al. 1998: 3).

Torgerson et al. note that the Competitive Yardstick School and its focus on service, competition, and efficiency created a:

...public policy rationale for supporting the organization of more cooperatives as a partial answer to farm price and income problem. The competition-enhancing rationale also became an important element in treatment under tax and antitrust codes (Torgerson et al. 1998: 3).

Torgerson et al. place much emphasis on the independence of American farmers. This seems to fit with Craig’s (1993) discussion of modified capitalism: “The school of modified capitalism suggests that co-operatives provide a decentralizing influence that counteracts the centralizing tendencies of corporate capitalism” (Craig 1993: 63). This view is not surprising in that the suggestion of socialism or communism in any form was to be avoided, especially during the McCarthy era and the Cold War; taken to its extreme, the school of modified capitalism argues that co-operatives “are not socialist in nature, or a separate sector. Rather they are the epitome of the capitalist ideal” (Craig 1993: 63). Emphasis is placed on how individuals through collective action can improve their economic wellbeing and also increase their personal freedom and individualism to a degree greater than that which they could otherwise achieve. In Craig’s (1993) view, it is this school which is the dominant one in the United States.

Co-operatives have also been used as a means of social control in developed countries, as well as developing ones. Bantjes (2007) notes that in Canada, politicians and government officials were:

...most keen on co-operatives where the threat from more radical forms of organization was greatest. Departments of agriculture, fisheries, and even

special departments of co-operative development were using funds and fieldworkers in an effort to channel popular activism away from socialism and toward forms of economic reform more compatible with capitalism (Bantjes 2007: 61).

For instance, the establishment of agricultural co-operatives on the Prairies was at least in part driven by class differences between eastern capitalist interests and the immigrants who became farmers. Politicians and officials feared that the settlers who came from Eastern Europe and England brought ideas about socialism, trade unionism and radical action with them. Co-operatives were viewed as a means of shielding farmers from the effects of the market, making them less dependent on single commodities, and avoiding radical reactions to global capitalism (Bantjes 2007: 55). Nonetheless, many farmers pursued the dream of a co-operative commonwealth to replace capitalism.

Little attention is given by Torgerson et al. (1998) to the Co-operative Commonwealth School, perhaps because of its ideological basis in utopianism. The idea of a Co-operative Commonwealth originated with the British co-operative movement in reaction to the unfettered growth of the capitalist economy during the Industrial Revolution (Bantjes 2007: 44; Bonner 1961: 461; Craig 1993: 53; MacPherson 1979: 4). The Rochdale Pioneers were influenced by utopian ideas of people such as Robert Owen when they established their co-operative in 1844: "...they would create a utopian community (self-supporting home colony) in which nonexploitive social and economic relationships would be achieved" (Fairbairn 1994). The concept of a Co-operative Commonwealth was not unique to England and was supported in Canada, France, Sweden and the United States (Bonner 1961: 467). There was some debate about what a co-operative commonwealth would consist of and how it could be achieved, but in general the goal was to achieve a new order in society.

This approach has never resulted in the achievement of a full-fledged new social

order, but the Co-operative Commonwealth School did have a considerable impact on Saskatchewan, notwithstanding claims by Torgerson et al. (1998) that co-operatives in North America sprang up independently of such utopian influences. In fact, the school's influence was so strong that it contributed to the formation of a social democratic political party that has enjoyed considerable periods of power as the elected Government of Saskatchewan (Johnson 2004), and of several other provinces, notably British Columbia and Manitoba. This was, of course, the Co-operative Commonwealth Federation (C.C.F.), now known as the New Democratic Party.

In summary, these different streams of co-operative thought illustrate that, depending on political ideology, governments perceive co-operatives as playing different public policy roles. In many developed economies of the West, governments see co-operatives as acting as a competitive yardstick and as serving as a check and balance to the private sector, thus levelling the playing field. The founders of co-operatives frequently take a different view of the role that co-operatives play; because of their grassroots orientation, co-operatives provide members/producers/ users and communities with control over the delivery of goods and services. For many founders, co-operatives support the development of what they view as a better society.

2.2.1 Proposition One

The preceding examination of the literature on the social economy in Canada and on the roles that co-operatives can play in society shows that the views of the government and the social economy, and the views of co-operative founders and government are not

necessarily congruent. It is therefore suggested that the following would be found with respect to co-operatives, as social economy organizations.

Proposition One:

The views of the government and those in the social economy can differ and conflict. While co-operative founders believe that the co-operative model of social economy organization allows their members to achieve control over the delivery of the goods and services they need, with the underlying ideology promoting a vision of a better society, government believes that co-operatives serve a public policy role by acting as a check and balance and serving as a competitive yardstick to the private sector.

2.3 Co-operative – Government Relations

The literature on government–co-operative sector relations in Canada is somewhat dated but continues to be relevant to this research. The relationship between co-operatives and governments is complicated by the division in powers between the federal, provincial and territorial governments, different levels of support for and recognition of co-operatives, variations in government structures addressing co-operative policy and programs, and difficulties the co-operative sector has in having its issues and concerns addressed (See Appendix Five for a discussion of the division of powers between the federal, territorial and provincial governments with respect to co-operatives).

This section begins with a historical overview of government–co-operative relations in Saskatchewan, and then delves into literature that provides potential answers to the question: Why did co-operative – government relations develop the way they did?

2.3.1 The Government and the Co-operative Sector in Saskatchewan

Co-operatives have played, and continue to play, an important role in Saskatchewan's economic and social development (Fulton, Hammond Ketilson and Simbandumwe 1991;

Hammond Ketilson et al. 1998; Herman and Fulton 2001). For its size and population, Saskatchewan has a large co-operative sector such that co-operatives have had a “significant place” in government policy (Fairbairn 2000). The scope, placement and size of the Saskatchewan government’s capacity to address co-operative policy and co-operative development has varied considerably over the years, with changes in political party at the helm of the government as well as changes in political priorities. Fairbairn (2000) suggests that a key question in examining government–co-operative relations in Saskatchewan is “how best to place what is effectively an interdepartmental policy area within a strongly departmentalized civil service” (Fairbairn 2000: 29).

Fairbairn (2000) describes three stages in the history of government–co-operative relations in Saskatchewan: the first from 1913 to 1944; the second from 1944 to 1982; and the third from 1982 to 1999. During the first period, responsibility for co-operatives resided in the Department of Agriculture. This made sense at the time because of the growth of the co-operative movement among farmers, who needed to pool and market their grain themselves and to obtain farm supplies at reasonable costs, instead of having dominant Eastern Canada interests control and profit from their efforts. Although the government did not start the co-operative movement in the province (Fairbairn 2000: 30), it did provide support for co-operative development.

Eventually, other kinds of co-operatives were formed, such as retail co-operatives and credit unions, and it no longer made sense to house responsibility for co-operatives in the Department of Agriculture (Fairbairn 2000: 31). The co-operative movement outgrew the capacity of one branch in that department. When the C.C.F. became the governing party of the province in 1944, it established a department wholly devoted to co-operatives – the

Department of Co-operation and Co-operative Development (Fairbairn 2000:31).

MacPherson (1984) notes that: “Even the name of the new political party, the Co-operative Commonwealth Federation, was partly an attempt to build on the widespread support gained by the Canadian co-operative movement since the turn of the century, particularly on the prairies” (MacPherson 1984: 161).

The Department of Co-operation and Co-operative Development focused on promoting the development of new types of co-operatives in the 1944-1982 period but, for the most part, did not address the concerns and issues of the established co-operatives:

In retrospect it is striking how little the established co-operatives and the C.C.F. government had to do with one another. While there were numerous ideological and personal connections, there were few joint initiatives, partnerships, or government programmes or initiatives to assist established co-operatives. In some respects the apparently close alliance between the co-operative movement and the C.C.F. was an illusion. While the followers of the two movements shared overlapping reformist visions, there were few close connections between government programmes and co-operative organizations (Fairbairn 2000: 31-2).

Many of the new co-operatives developed in the second stage of government-co-operative sector relations would not have been established without government intervention (Fairbairn 2000: 32). Yet, development was not pursued in many situations where there were opportunities. The Medicare crisis occurred during this time but the government did not pursue the development of co-operative Community Clinics:

One of the most promising forms of co-operative developed in this period was the consumer-sponsored health-services co-operative (community clinic). However, the controversy associated with the emergence of these co-operatives in the doctors' strike of 1962 led the C.C.F. and all subsequent governments to distance itself from them. As a result, a promising model within an area of public responsibility was not actively promoted (Fairbairn 2000: 32).

Fairbairn (2000) calls the third period an “era of experimentation that has not ended”. The Progressive Conservative (P.C.) government under Premier Grant Devine eliminated the Department of Co-operation and Co-operative Development in 1987¹. Responsibility for co-operative incorporation, legislation and regulation went to the Department of Justice; responsibility for co-operative development and government–co-operative sector liaison was housed in a Co-operatives Branch in the Department of Economic Development and Trade. The number of staff assigned to the branch was drastically reduced.

The P.C. government was very much focused on large-scale economic development projects and entered into an arrangement with Federated Co-operatives Limited (FCL) to sponsor the building of a heavy oil upgrader at FCL’s refinery in Regina (Fairbairn 2000: 34). The province provided much of the funding required for this venture. Where there were new co-operatives developed, much of this activity was prompted by government programming that was not specific to co-operatives (Fairbairn 2000: 34). For instance, the Small Business Loans Association program provided equity for small business development is still in operation today (Enterprise Saskatchewan website).

In 1991, the N.D.P. was re-elected. In response to concerns voiced by the co-operative movement, in 1992 the government established a Co-operatives Directorate with an Assistant Deputy Minister responsible for co-operatives in the Department of Economic Development². The directorate was intended to be the focal point for government-co-operative sector relations and was involved in co-operative policy and program development.

¹ I worked at the Department of Economic Development and Trade at that time and have firsthand knowledge of this event, and of government-co-operative sector relations since then.

² I was employed as a Senior Policy and Program Co-ordinator in the Co-operatives Directorate from May 1992 to September 1997. The discussion in the rest of this section is based on my own experience during that time.

When the Department of Rural Affairs was disbanded, the directorate also acquired responsibility for community economic development.

The establishment of the directorate raised the profile of the co-operative sector for a time. The directorate prepared a Cabinet-approved mandate setting out how the government would work with and support the co-operative sector, and the name of the department was changed to Economic and Co-operative Development. The Assistant Deputy Minister for Co-operatives had been the Executive Director of the Regina Community Clinic for 12 years before coming to government. While he was in the Co-operatives Directorate, he made several approaches to the Department of Health to include the co-operative model in the Wellness approach and in other plans for the restructuring of health care in the province. His overtures were rebuffed by officials in the Department of Health (Marwick 2005).

The decision was made to dissolve the directorate in 1998 and to disperse responsibility for co-operative development among other branches in the department. Co-operative development specialists were assigned to the Small Business unit. The Assistant Deputy Minister position was abolished and the remaining staff was reassigned to other units.

The question of how best to situate responsibility for co-operative policy, programming and development support within government remains unanswered (Fairbairn 2000). Placing responsibility for co-operatives within an influential line department such as Economic Development could, in theory, be beneficial to the co-operative movement. However, this department was very focused on the dominant business structure and did not understand the associational aspects of co-operatives or that economic and social development go hand-in-hand (Marwick 2005). On the other hand, placing responsibility for co-operatives in a central agency would isolate it from the departments dealing with co-

operative matters. Childcare co-operatives, for instance, are the responsibility of the Department of Education and grazing co-operatives come under the purview of the Department of Agriculture.

There was further restructuring of government departments. In 2005, a Department of Rural Development was re-established and responsibility for co-operatives was assigned to it (Government of Saskatchewan. News Release, March 11, 2005). Co-operative development staff were incorporated into regional offices, which deal with business services. In the budget of 2006, this department was renamed Regional Economic and Co-operative Development. However, there has been little capacity to undertake co-operative policy development since the Co-operatives Directorate was disbanded in 1998.

For a time, it seemed that political interest in co-operatives was increasing yet again. In 2005, the Co-operative Advisory Council was established to:

...provide a forum for senior representatives of Saskatchewan Co-operative Association (SCA), its member co-operatives, and other invited co-operative organizations to meet with the Minister of [Regional Economic and Co-operative Development] and other government representatives to discuss high level issues relevant to both SCA and the government including but not limited to:

1. Legislation, regulations, policies, programs, and services initiated by the Provincial Government that impact on the development, operation, and growth of co-operatives and credit unions in Saskatchewan;
2. Co-operative and credit union sector strategies and initiatives of interest to government, or where supportive action by the government is required, and
3. Issues of mutual concern and to establish joint strategies to enable the co-operative and credit union sector to work in partnership with the government to address them (Co-operative Advisory Council Terms of Reference, unpublished).

More drastic changes came with the election of November 2007. The Saskatchewan Party achieved a majority government and reorganized government departments and

agencies. The former Department of Regional Economic and Co-operative Development was renamed the Ministry of Enterprise and Innovation. This ministry was charged with establishing a new arm's length organization called Enterprise Saskatchewan to be the focal point for economic development planning in the province. Enterprise Saskatchewan was formally established in July 2008 (Government of Saskatchewan. News Release. August 1, 2008). The implications for co-operative policy, programming and development are not yet known, although a Co-operatives Sector Team has been established to make recommendations to remove barriers to growth and build on competitive advantages.

Fairbairn's (2000) analysis of government policy toward co-operatives concludes that it varies based on political interests and priorities. Although there have been some differences in the ways that the political parties have related to co-operatives, "it has arguably never been a basic political goal of any government to promote co-operatives simply for the sake of promoting co-operatives...government policy as a whole firmly supported co-operatives only when there was a larger, practical goal in sight" (Fairbairn 2000: 36).

In Canada, government support for co-operative development and government capacity structures to address the needs of co-operatives vary over time and according to government priorities. Generally, governments do not adequately address co-operatives in their programming, policies, structures, budget allocations, and legislation.

2.3.2 Co-operatives and Policy-Making

Fulton and Laycock (1990) conclude that co-operatives will continue to receive less than their fair share of policy influence because they are non-capitalist entities in a capitalist political economy. The formal logic of state decision-making limits their effectiveness.

Their democratic structures make it almost certain that in their policy activities co-operatives will adopt an advocacy role that their members see as engagement with politicians on issues that are important to them. At the same time, the formal structures of their organizations will often result in co-operative managers and leaders wishing to engage more directly in policy-making, with government officials responsible for policy decisions. There is a difference between how the members and the managers of co-operatives approach advocacy; co-operative members are part of a policy community which operates at some distance from the network of decision-makers; managers and leaders want to be involved in that network. Policy networks and communities continue to be the subject of ongoing research (Skogstad 2005; Monpetit 2002) and remain relevant to an examination of how nongovernmental organizations participate in the policy process.

Co-operatives have been somewhat suspicious of maintaining close relations with federal and provincial governments. Fulton and Laycock (1990) note that this finds expression as “a disinclination to become involved in broad-ranging public policy discussions and an opposition to expansion of state enterprise except where this directly promotes co-operatives’ institutional interests” (Fulton and Laycock 1990: 142-3). They attribute this attitude to co-operatives’ belief that an interventionist state might intrude on economic and social activities within which co-operatives have found their market niche. It is also related to their frustration with governments that early on “facilitated the domination of the average citizen by distant economic elites” (Fulton and Laycock 1990: 143). The co-operative movement’s practice of political neutrality is also a factor; increased participation in partisan policy development or political activity might contravene this practice. The result is “a profound yet unarticulated uneasiness about co-operative-state relations” (Fulton and

Laycock 1990: 143), which ultimately impacts co-operatives' ability to effectively influence government policy.

Fulton and Laycock (1990) delineate two main types of influence that pressure groups can exercise; these are traditional lobbying or policy advocacy, and actual policy-making and implementation. The groups engaging in such activities are often referred to as policy communities, in the first instance, and policy networks in the second (Skogstad 2005; Atkinson and Coleman 1996).

In order to effectively influence government policy formation, pressure groups must be able to mobilize support among either their members or the public, or both. This means that there must be considerable consensus among members. Members must believe that the group does, in fact, represent their interests, and cohesion signals to the government that the group has legitimacy. Fulton and Laycock (1990) suggest that lobby or advocacy efforts need to be narrowly focused to represent the views of members, and to make statements and decisions for them; this implies that regional or industry-specific groups may be more successful than large co-operatives with diverse memberships. Members tend to be issue-oriented and focused on achieving short-run objectives; they therefore may have minimal knowledge of government policy-making processes and players.

To be involved in policy-making, groups need to be able to “order and co-ordinate large amounts of detailed and technical information, and remain relatively autonomous from both their members and the government” (Fulton and Laycock 1990: 145). Maintaining autonomy is seen as particularly important because “group negotiation and compromise with both state and other groups in the economy is fundamental to policy participation” (Fulton and Laycock 1990: 145). Organizations, for instance private corporations or private sector trade associations, have

advantages over membership-based groups such as co-operatives in proposing policy changes. The interests of organizations engaged in lobbying are not necessarily those of its members, so to the extent that organizations have political power, this does not depend on a legitimation process. The decision to influence public policy is a management decision and managers have a great deal of independence in decisions they make.

Corporations and business associations often have greater financial resources than membership-based organizations, and have greater freedom to exert pressure on policy makers (Fulton and Laycock 1990: 145). They tend to be more stable over the long run and are able to develop extensive knowledge of government process and players. Within a co-operative, however, the decision to influence public policy is not the manager's to make. The decision must be made by the board, taking into consideration the varying interests of the co-operative's members. Because of heterogeneous interests among members, consensus may not be possible. The democratic process that must take place may hinder the co-operative from acting quickly (Cook 1994; Hammond Ketilson 1990; Fulton and Laycock 1990).

As membership groups with a democratic structure and member commitment, co-operatives should be well positioned for success in policy advocacy. However, their dual nature means that they are also organizations with hierarchical and bureaucratic structures. Because of this, "directors and management often take independent action on both commercial and policy fronts" (Fulton and Laycock 1990: 148). Co-operatives' dual nature can result in conflicts between policy advocacy and policy-making roles, reflecting the tension between what members want and what managers want.

In summary, the literature on government – co-operative sector relations in Canada provides evidence that government officials lack knowledge and understanding of the co-

operative model. Moreover, structural and governance issues constrain co-operatives in their advocacy and lobbying efforts. Consequently, co-operatives and their associations are relatively ineffective in their lobbying and advocacy efforts and in participating in the policy-making process.

2.3.3 Categorizing Government Treatment of Co-operatives

Government's approach to co-operatives can take many forms. Because there is so much variation in how governments treat co-operatives, a means of categorizing how governments treat co-operatives as social economy organizations is a useful heuristic device to compare treatment over time and according to which political party is in power within the same jurisdiction. It also allows comparison among different countries.

As Hoyt (1989) notes, the fundamental dilemma underlying government treatment of co-operatives is what the role of government should be with respect to co-operative development:

Experience throughout the world has shown that government policies can impede or enhance independent co-operative development. The debate centers on the need to preserve autonomy and democratic control of the cooperative by its members, while recognizing the cooperatives' need, in some countries, to receive management and financial support from the government and to operate in a favourable legislative environment (Hoyt 1989: 88).

Hoyt (1989) identified a continuum of public policy toward co-operatives in her examination of how agricultural co-operatives have been treated by governments around the world. These conditions vary from country to country and can change through time as new political regimes gain power. Although the continuum speaks to the relationship between agricultural co-operatives and governments, it can be applied to other types of co-operatives.

This continuum is a useful guide for categorizing public policy on co-operatives. Hoyt (1989) categorizes government policy in five levels from outright hostility to complete control:

Figure 1 – Hoyt’s Continuum of Public Policy on Co-operatives

Type of policy level:	Destructive 1	Neutral 2	Supportive 3	Participating 4	Controlling 5
Description:	Antagonism, hostility, violent destruction	No public policy, positive or negative	Creation of favorable legal/business environment	Active provision of support services; may include management	Total control over cooperative management and decision-making

(Hoyt 1989)

At level 1, governments are hostile toward co-operatives and suspicious of them. They attempt to restrict, suppress or outlaw co-operatives. An example of this is the treatment that consumer co-operatives experienced in Nazi Germany:

In principle, the cooperatives, with their democratic ways of self-administration, did not fit into the political system and the socio-economic concept of National Socialism. On the other hand, the cooperatives had been able to develop strong market positions, so it was not possible simply to liquidate them, either. Liquidation was, however, inflicted upon the consumer cooperatives whose activity had a strongly socialist orientation which was to be repressed by smashing their organizational basis. At first all of their organizations including their associations and central enterprises were subjected to the command and disposal of the ‘Deutsche Arbeits-front’ (German workers’ front) while their nationwide associations were dissolved right away (Aschhoff and Henningsen 1986: 31).

At level 2, “the government does not actively attempt to destroy co-operatives, nor does it give them special treatment. In effect, co-operative businesses operate in the same climate as all other businesses. This limited involvement by government has been typical of

industrialized countries” (Hoyt 1989: 89). Government involvement in co-operative development in some Western industrialized countries has been limited because social or popular movements established co-operatives to meet their goals; co-operative movements in some industrialized countries were also built on strong traditions of independence, voluntarism and self-help (Hoyt 1989), reducing the need for government intervention. Treatment at this level could be considered to be “benign neglect”.

Policy makers at level 3 demonstrate:

...a positive attitude toward co-operatives as a tool that citizens can use to improve their economic well-being and participate in economic democracy. Artificial barriers to co-operative operations are removed. For example, special legislation may be passed to make it easier to organize and operate them. Education, research, and technical assistance programs are initiated to help co-operatives be successful. The aim of government is to encourage the development of co-operatives; however, responsibility for initiating and carrying through this development rests with members...the government is not actively involved in the day-to-day affairs of the co-operative, does not participate in co-operative management, and does not have representatives on the board of directors (Hoyt 1989: 90).

Level 3 appears to demonstrate a balance between government’s public policy goals and the need to maintain autonomy and democratic control by members. The environment established by government is enabling, not too controlling (as at level 4) and not too neglectful (as at level 2).

Given the history of co-operatives in Saskatchewan, it would appear that their treatment by the provincial government could be categorized as falling into level 2 or level 3. The government’s organizational structure for supporting co-operatives has ranged from very little profile, few staff and a nominal budget allocation within a department to an entire department dedicated to co-operation and co-operative development. The former is indicative of level 2 and the latter level 3. When the co-operative model has not been

regarded as useful in addressing government priorities, a neutral stance has been maintained; when the co-operative model has been instrumental, a supportive approach has been taken.

Co-operatives in Saskatchewan have not experienced the extreme treatment that levels 1 and 5 represent. An example of how co-operatives have been treated at level 5, at which governments have total control over co-operative decision-making and management, can be found in colonial policy. Develtere (1992) states that British colonial policy was: "...directed primarily to the maintenance of law and order so that trading companies might pursue and expand their business" (Develtere 1992: 40). In India, co-operative operations and administration were closely monitored and actively directed by British colonial administrators. The Belgian colonial development strategy included co-operatives as an interim measure for managing colonial economies until capitalism could be established (Develtere 1992).

In summary, Hoyt found that governments treat co-operatives in different ways and that these practices vary from country to country, and over time within the same country as political regimes change. Hoyt notes that in industrialized countries, the governments are typically fairly neutral toward co-operatives. Co-operatives are not accorded any special treatment but they are not actively destroyed (Hoyt 1989).

2.3.4 Definitional Issues and the Ideal Co-operative

Hoyt's continuum attempts to encompass the full range of treatment that co-operatives have experienced and continue to experience around the world. This range is reflective of the many different ways that governments conceptualize co-operatives and their roles in public policy and in society. As Hoyt notes, "not all countries require businesses to

conform to the ICA principles in order to be considered co-operatives” (Hoyt 1989: 82). The democratic governance of co-operatives is particularly at issue.

Just as there is some confusion about how the social economy can be defined and understood, there is similar confusion about co-operatives. The International Co-operative Alliance (ICA), the penultimate association of co-operative associations, issued a statement on the co-operative identity following extensive consultation with co-operative organizations around the world (see Appendix One for the ICA’s statement, co-operatives principles and values). This document included the following definition:

A co-operative is an autonomous association of persons united voluntarily to meet their common economic, social, and cultural needs and aspirations through a jointly-owned and democratically-controlled enterprise (MacPherson 1996).

This definition probably comes the closest to being universally accepted, but there are many others. For instance, the United States Department of Agriculture, which houses a rural co-operative development service, states that: “In general, a cooperative is a business owned and democratically controlled by the people who use its services and whose benefits are derived and distributed equitably on the basis of use” (USDA1997). Put another way, the USDA’s definition boils down to user-ownership, user-benefits and user-control.

Co-operatives are one form of organization under the umbrella of social economy organizations, but the many definitions of co-operatives contribute to the confusion around understanding some co-operatives, or indeed some social economy organizations.

Democratic governance and member participation and control are key features of co-operatives. In contrast, social economy organizations may not be member-controlled but deliver the same kinds of services, for instance, health care, and are closely linked to government. Although member-owned, there are co-operatives which deliver health care

services that are also closely linked to government. The latter, among them the Community Clinics in Saskatchewan, may not be considered “pure” or ideal-type co-operatives, but there are many degrees of “co-operativeness”.

Their close linkage to and almost complete dependence on government is what led the co-operative movement in the province to withhold its support for the Clinics earlier in their history. At one time, the co-operative movement did not consider the Clinics to be “real” co-operatives (Transcript 37). The distance between the co-operative movement and the Community Clinics does not exist today, but the Clinics could still be viewed as being not quite “real” or genuine co-operatives. The way in which they observe member economic participation and autonomy and independence is different from what is considered the norm for co-operatives, as expressed in the co-operative principles:

3rd Principle: Member Economic Participation

Members contribute equitably to, and democratically control, the capital of their co-operative. At least part of that capital is usually the common property of the co-operative. Members usually receive limited compensation, if any, on capital subscribed as a condition of membership. Members allocate surpluses for any or all of the following purposes: developing their co-operative, possibly by setting up reserves, part of which at least would be indivisible; benefiting members in proportion to their transactions with the co-operative; and supporting other activities approved by the membership.

4th Principle: Autonomy and Independence

Co-operatives are autonomous, self-help organizations controlled by their members. If they enter into agreements with other organizations, **including governments** [emphasis added], or raise capital from external sources, they do so on terms that ensure democratic control by their members and maintain their autonomy.

Member economic participation means that they contribute the capital on which co-operatives, at least initially, are run. Typically, this contribution of capital ensures that the members remain in control of their organizations. Community Clinic members contribute a

nominal amount in the form of membership fees and additional funds are raised through Clinic foundations established for that purpose, but otherwise members do not participate in the economic affairs of their co-operatives in the same way that members of other kinds of co-operatives do. This is what distinguishes the Community Clinics from other co-operatives. Members do not provide the funds but still expect to have control over the Clinics.

It is the observation of the 4th Principle that is the most problematic for both the Clinics and the government, but for different reasons. The Clinics fear the loss of their autonomy and independence, and government and health region officials bemoan their inability to control them (Transcripts 1, 11, 31). The Clinics are public service providers but are not controlled as public sector organizations by the government. This is at the heart of the tension in the relationship between the Clinics and the provincial government.

The Clinics thus cannot be fully conceptualized as co-operatives. Nor can they be fully conceptualized as public sector entities, even though they receive almost all of their funding from the government and deliver a public service. They are also not private sector organizations, although they do appear to be conceptualized by the provincial government as another form of private practice. The Clinics' very uniqueness among co-operatives suggests that it may be possible to consider them as something else, possibly as hybrids. There are growing streams of literature on the third sector and public governance (for instance, see Pestoff 2009; Brandsen and Pestoff 2008) and the emergence of hybrids in the social economy (for instance, Evers 2005; Graefe 2006). Viewing the Community Clinics as hybrids has implications for how they have been, and still are, treated by government. This is explored later in the study.

2.3.5 Co-operative Legislation in Canada

The existing literature on co-operative legislation in Canada has suggested that co-operative legislation is based on business corporation law and that this causes systemic problems for co-operatives. This is perhaps not surprising because the state appears to be oriented toward the private sector with the business corporation as the dominant form by which it is organized and acquires legitimacy.

Axworthy (1990) discusses the constraints that co-operative legislation in Canada places on co-operative organizations with respect to their prescribed structure, powers of control and decision-making, and member participation. Since co-operatives are both economic and social institutions, non-economic considerations come into play in selecting an organizational form. Because co-operatives have other objectives than maximizing profit, what is rational for them will depend on the mix of social and economic aims to be pursued. These different aims give rise to different interpretations of efficiency (Axworthy 1990: 40).

Axworthy (1990) states that: “Perhaps the main consequence of this legislated regime is the requirement that co-operatives adopt an organizational and managerial structure based on elite democratic theory even though they espouse participatory democratic ideals” (Axworthy 1990: 41). According to Axworthy (1990), co-operatives are required to elect a board of directors and appoint specified officers, and they are required to develop formal hierarchies; the legal regime specifies that co-operatives must elect representatives to manage the organization rather than operating on the basis of participatory decision-making. Axworthy notes that the structure required by co-operative legislation in Canada is inconsistent with the democratic principles of co-operatives: “The fact remains that

participatory democracy and the legal regime borrowed from corporation law and practice do not fit together” (Axworthy 1990: 41).

Ish and Ring (1996) note that:

...modern Canadian co-operative legislation displays amazing similarity with ordinary corporate legislation thus camouflaging the fact that co-operatives are distinct from ordinary business corporations which base control on investment and which possess hierarchical management structures (Ish and Ring 1996: 104).

Ish and Ring (1996) also note that because there has been little by way of court decisions dealing with co-operative legislation, and the ones that have been taken were largely influenced by previous interpretations of corporate legislation.

The federal *Canada Cooperatives Act* that was proclaimed in June 1999 does not appear to have removed or mitigated the influence of corporate law on co-operative legislation. The new legislation replaced the old *Canada Cooperative Associations Act* of 1970, but was still modeled in large part on the *Canada Business Corporations Act*. While modernizing the corporate statute law on co-operatives, the influence of the dominant corporate model can be seen in some of its provisions. For instance, the Act:

- Enables members of co-operatives to decide on whether to issue equity in the marketplace on a competitive basis, while retaining a co-operative structure.
- Provides greater flexibility of methods for members to finance their co-operative by giving access to new ways to raise capital if members decide that internal financing is not enough.
- Makes directors subject to a statutory duty of care and fiduciary duty — modernizes, clarifies, and limits these duties.
- Allows for a good mix of qualified individuals to serve on the board of directors of a co-operative by permitting members to elect (limited) outside expertise. At least 2/3 of a co-operative's directors must either be members of the co-operative or representatives of members that are co-operatives, business corporations, or other entities: 1/3 of the directors may be outside directors. If the co-operative issues investment shares to non-members, members may decide to authorize investment shareholders

- to elect no more than 20% of the directors.
- Gives co-operatives access to an array of modern corporate tools (e.g. amalgamations, arrangements, and reorganization) that competitors use everyday to carry on business efficiently and effectively.
- Harmonizes aspects of the *Canada Cooperatives Act* with similar provisions in the *Canada Business Corporations Act* (CBCA) (Canadian Co-operative Association. Co-op Legislation).

In summary, this brief exploration of the legal regime points to its importance as an instrument of public policy. It seems that in Canada, government conceptualizes co-operatives as business corporations, which results in many aspects of business corporation legislation being embedded in co-operative legislation. This gives rise to systemic tensions for co-operatives.

2.3.6 Proposition Two

The preceding examination of three streams of the literature on co-operative – government relations shows that the government in Saskatchewan has used the co-operative model to meet public policy goals and that these goals have changed over time and according to the ideology of the governing political party. It has also shown that co-operatives experience structural challenges in participating in the policy-making process, both through legislation based in large part on business corporation legislation and through their own decision-making process. Finally, governments approach co-operatives in many different ways. All of these factors affect co-operatives' ability to participate effectively in public policy-making. It is therefore proposed that:

Proposition Two:

Co-operatives can be expected to have little influence on government policy, except where their ability to act as a check and balance or competitive yardstick may address government priorities.

2.7 Conclusions

This chapter has reviewed streams of literature on government-co-operative sector, the roles of the social economy in Canada, and the roles that co-operatives play in society. It has also reviewed literature on the legal structure of co-operatives, categories of government treatment of co-operatives, and co-operatives and the policy-making process.

Different conceptualizations of co-operatives and the roles they play affect the relationship between co-operatives and governments and contribute to its complexity. Co-operatives need governments because they control the policy environments in which co-operatives operate, as well as providing funding, development, research and other supports. Governments need co-operatives to play a number of different public policy roles; however, they are often conceptualized as business corporations, if they are conceptualized at all. When governments do support the co-operatives model, it does so to meet specific public policy goals; thus government support for co-operatives waxes and wanes according to government priorities. Co-operatives operate in complex political, economic and social environments, where public policy goals and priorities shift continually. Two propositions that arise from these streams of the literature have been identified:

Proposition One:

The views of the government and those in the social economy can differ and conflict. While co-operative founders believe that the co-operative model of social economy organization allows their members to achieve control over the delivery of the goods and

services they need, with the underlying ideology promoting a vision of a better society, government believes that co-operatives serve a public policy role by acting as a check and balance and serving as a competitive yardstick to the private sector.

Proposition Two:

Co-operatives can be expected to have little influence on government policy, except where their ability to act as a check and balance or competitive yardstick may address government priorities.

The next chapter focuses on concepts and theories from literatures dealing with public policy and policy-making processes, the role of ideas and ideologies in public policy, power relationships, and interest group-government relations. These are all areas of scholarship that can contribute to understanding the relationship between the Community Clinics and the provincial government of Saskatchewan.

CHAPTER THREE: POLICY PROCESSES AND POLICY-MAKING

3.0 Introduction

In this chapter, concepts are drawn from the research on public policy and the policy-making process, business–government relations, conceptions of power relationships, and the role of ideas and ideology in public policy-making to build an appreciation of how these areas of scholarship inform an understanding of co-operative – government relations. Definitions of “public policy” and of “policy analysis”, along with a discussion of policy-making processes and the constraints around them, are provided first. The role of ideas and ideology in the public policy-making process and the conditions necessary for policy change are then explored. Conceptions of power relationships between social economy organizations and governments are discussed, followed by an examination of business – government relations. A framework for examining the primary data assembled for this study is then set out.

3.1 Public Policy and the Policy-Making Process

There are many definitions of public policy (Howlett and Ramesh 2003; Pal 1987; Stanbury 1993), but generally a public policy is a statement about what a government will do to address a particular problem or to achieve a particular goal. The development of public policy is related to government priority-setting and mandate (Doern and Phidd 1992), and involves decisions about resource allocation.

This is a simple statement but public policy development is complex, with many different players and structures involved. There are, in fact, many different public policy processes. Further, policy takes many forms and they are not necessarily mutually exclusive;

the relevant forms include but are not limited to legislation, regulation, ministerial speeches, briefing notes, the annual expenditures budget, and cabinet decision items. There are variations in how policy is developed; there can be what Stanbury refers to as “hard” methods like cost-benefit analysis and “soft” methods such as consultation (Stanbury 1993).

Governments also have numerous instruments at their disposal to operationalize their policy decisions; these can include legislation and regulation, grants, and transfer payments, among others.

Government inaction is also an option; by choosing not to take action to address a problem or opportunity, the government indicates its policy. There can also be “policies without resources” (Doern and Phidd 1992): “Many governments find it necessary to enunciate policy to express their concern about, and support for, a particular constituency or group, since this is usually preferable to expressing no public concern whatsoever” (Doern and Phidd 1992: 58). In this case, a policy consists of rhetoric only and does not utilize any of the available policy instruments; it merely serves the purpose of “waving the flag”.

In addition to the different definitions of public policy, there are also different conceptualizations of the stages or steps involved in policy development and analysis. In general, there are several stages in addressing a policy problem: problem identification; definition; search for alternative instruments that would best address the problem; choice of alternative and resources allocated to it; implementation; and evaluation (Bardach 2009; Geva-May and Pal 1999; Howlett and Ramesh 2003; Smith 2005). This process is an iterative one; there are feedback loops built into every stage. The process generally applies to routine policy generation as well as responses to emergent situations or crises, although in crises some steps may be omitted because of time constraints.

3.1.1 The Actors in the Process

The analysis of policy options has many complicating factors associated with it, which have much to do with who has power and control. As Doern and Phidd (1992) point out, government ministers (the most senior elected officials) rarely get to make one decision at a time; they are normally faced with making multiple decisions, complicated by multiple processes running simultaneously. Ministers also have to balance ideologies and dominant ideas of efficiency, equity, individual liberty, redistribution, and, in the case of the federal government, national unity and regional sensitivities (Doern and Phidd 1992). Ministers have to make policy decisions with finite available resources and limited information. They are also influenced by the desire to be re-elected, and make decisions based on where they are in terms of the electoral cycle; priorities shift over time. The desire for elected officials to be elected and re-elected underlies the framework for understanding the relationship between business and government described later in this chapter. Finally, ministers seldom have one area of responsibility so they are dealing with multiple areas simultaneously. This impacts on the amount of information they can digest with respect to any single policy decision.

The bureaucracy plays a key role in the public policy process. Doern and Phidd (1992) describe the bureaucracy as having structure, as in multiple departments and agencies each with their own mandate, as “a system of delegation that immediately creates an impetus for ‘bottom-up’ policy initiatives emanating from departments that have their own agendas reinforced and challenged by their own policy communities” (Doern and Phidd 1992: 154), and as consisting also of senior officials who have both positive and negative influence over their ministers through their daily interactions. The bureaucracy is the site of competing

interests, conflicting and overlapping mandates, and “turf protection”, making co-ordination of policy initiatives difficult. The power of the departments and agencies and of the senior officials varies with government priorities; this is further complicated by frequent reorganizations and changes in structure and personnel.

Doern and Phidd (1992) describe the relationship of cabinet ministers with their senior officials as one of mutual dependence because ministers may prefer to devote their time and attention to policy and political party matters and leave the administration of their departments to the senior officials, who must also be policy advisors to their ministers and be aware of their political constraints and concerns. The responsibility of senior officials for both policy and administrative matters leads to concern about their political neutrality, especially when a new government comes into power, but:

...the core of the concern about the role of senior public servants and senior advisers in policy formulation centres on their role in initiating policy ideas and proposals, analyzing and “massaging” policy proposals, and in blocking or frustrating the plans or ideas of elected politicians. It is evident that bureaucrats have a considerable capacity to initiate policy. In part the political system expects and encourages them to do so when it berates them on those occasions when they have failed to plan, to estimate costs and effects adequately, and when legislators leave wide discretionary powers in their hands or assign such powers to separate boards and agencies. The reality of decision-making in a complex Cabinet-bureaucratic structure is that policies are not always clear, frequently conflict with each other, and must be constantly reinterpreted as they are applied to single cases or projects (Doern and Phidd 1992: 165).

This would suggest that given the complexity of the relationship between a minister and his/her senior officials, there may be a divergence in their goals: “... policy is always at least partly the outcome of day-to-day relations between senior officials and ministers as they each seek to play their prescribed administrative and political roles in the face of a changing agenda” (Doern and Phidd 1992: 170).

Interest groups also have a key role to play in public policy-making and are as varied as the government structures and processes they attempt to influence. As well as attempting to influence government to take policy decisions that would be to their benefit -- and perhaps to the benefit of society as a whole -- they have other roles to play in a democratic society. According to Stanbury (1993), they can serve as signalling mechanisms to government with respect to the preferences of citizens between elections; they can aggregate interests which are easier for governments to deal with and provide a means by which individuals can participate in the policy process; they can provide information to government because they possess specialized technical knowledge about political support for proposed and existing policies; they can act as information conduits from their members to government, from government to their members, to other interest groups from government, and facilitate communication within government; and they can act as agents of government in the delivery of services (Stanbury 1993: 119-120).

According to Stritch (2007), there has been little attention given to the role that business associations play in policy-making in Canada and “very little is known about the scope and character of policy analysis by business groups.” His own research has found that there is “considerable variation in the extent to which groups engaged in policy analysis”, that policy analysis activity by business groups has become more extensive in recent years, and that there is a shift toward increased privatization of policy analysis in Canada because of budgetary constraints in the public sector. Prevailing neoliberal tendencies no doubt have something to do with this tendency as well.

There has also been little scholarly work done on provincial governments and their policy-making processes despite the fact that “the largest proportion of policy development,

adaptation and change is concentrated in the provincial sector” (McArthur 2007). The reason for this seems to be insufficient information on how provincial governments work:

It also appears that provincial governments are not particularly introspective or self-conscious, adding to the paucity of reliable information. Provincial governments produce relatively few reports on their findings, and those that are produced are not readily accessible. Provincial government officials are arguably skeptical about theory and the study of how government works, and see the management of government as a very practical matter (McArthur 2007: 238).

In summary, there are many conceptualizations of what public policy is and how it is developed. There are many different actors with different ideas, values and goals; many instruments through which public policy can be effected; many forms that public policy can take; and, numerous constraints to the process. Relationships among the actors, the issues and the processes are frequently complex. Interest groups outside of government often find that achieving their goals in this environment is highly challenging.

3.2 The Role of Ideas and Ideology in Policy-Making and Policy Change

Just as there are numerous definitions of public policy and understanding of the policy analysis process, there are different conceptualizations of the conditions necessary for policy change to occur. There are some common concepts about the role of ideas in policy-making. One is that ideas play a very important role and that dominant ideas dominate public policy. As Doern and Phidd (1992) point out, “ideas both influence and are embedded in the structures and processes of policy-making”. At the nexus of our system of government is the following understanding:

The central tenet of democratic politics, especially in a cabinet-parliamentary system, is that political parties offer a program of policies to the electorate and that the victor at the polls, expressed in parliamentary seats, possesses a majoritarian mandate to carry out its policies. The assumption is that

democratic life is purposeful, a peaceful contest over contending ideas, preferences, and objectives. The assumption is that political power or the gaining of political office is a means to carry out policies, not that policies are a means to gain office (Doern and Phidd 1992: 35).

Hall (1993), Howlett and Ramesh (2003), and Doern and Phidd (1992) set out similar concepts with respect to the role of ideas in policy-making; all characterize ideas as having several different levels. Doern and Phidd (1992) describe a typology of ideas that distinguishes between four levels of “purposeful activity and thought.” These are: ideologies, dominant ideas, paradigms, and objectives.

Ideologies are the broadest level of ideas in this typology and are associated with liberalism, socialism and conservatism. Liberalism is defined as “a belief in the central role of the individual in a free society”, which includes a free market capitalist economy and a belief in scientific and technical progress (Doern and Phidd 1992: 36). The state’s role in this case is as “a benevolent reformist referee-like role, balancing the ideas and power of contending interests in an even-handed way”.

Conservatism’s goal is to “preserve valued and proven traditions”, with a belief in the market and in minimal government intervention, while also holding “an organic paternal view of society, of the need for the state and the community to care for those who cannot care for themselves” (Doern and Phidd 1992:37).

Socialism is based on a class analysis of society, and places less emphasis on the individual and more emphasis on a collective view of society. It is characterized by much more government intervention to effect a redistribution of wealth and power to disadvantaged classes and groups:

While seeing the need for a socialist state that will redistribute income, the socialist view is ambivalent about centralized power. Power must be concentrated to achieve redistribution in a capitalist society, but at the same

time there is fear among social democrats about the possible bureaucratization of that power (Doern and Phidd 1992: 37).

Doern and Phidd (1992) note that a particular feature of Canadian politics has been the adoption of major components of one ideology by another. A pertinent example is the adoption of Medicare by the federal Liberal government. At the same time, these ideologies “help foreclose certain policy options or reduce levels of commitment to particular courses of action and to particular ideas” (Doern and Phidd 1992: 38).

The next level of ideas in this typology is that of dominant ideas. As mentioned above, these ideas equate to values and how Canadians define themselves. It is important to understand these in order to understand public policy:

These ideas influence political debate and the “evaluation” of public policy *regardless* of the particular preferences stated in the legislation or the ministerial speech accompanying the particular policy or decision. These ideas are each desirable. They also often totally or partially contradict each other (efficiency versus regional sensitivity, or redistribution versus stability of income) (Doern and Phidd 1992: 41).

Much of the work of public policy is to prioritize among these dominant ideas and to allocate resources to them. Paradigms constitute the next level of policy ideas according to the typology. This is a narrower concept that is linked to particular policy fields:

A well-developed paradigm provides a series of principles or assumptions that guide action and suggest solutions within a given policy field. Paradigms can become entrenched and thus change very slowly because they become tied to the education and socialization of professionals or experts and perhaps of the larger public as well (Doern and Phidd 1992: 41).

An example of this is again found in health care policy that is dominated by doctors in a “medical” model focused on curing or treating those who are already ill or injured. The countering paradigm is that of a health promotion and prevention approach, which is less dominated by doctors (Doern and Phidd 1992: 41). This level is important because policy

paradigms can also screen out policy options and “alert us to the role of professional experts who have power partly because they are the successful purveyors of the dominant paradigm”.

The fourth level of policy ideas consists of specific objectives related to particular policy arenas: “It includes the more specific purposes that may be debated or be in dispute within a policy field”. It is the narrowest form of policy ideas in the typology and although important, Doern and Phidd suggest that “the study of public policy must begin with an appreciation of the broader levels of democratic political life. It does not begin with a search for ‘objectives’ only” (Doern and Phidd 1992: 42-43).

Howlett and Ramesh (2003) also discuss the connection between ideologies and policy paradigms, noting that established beliefs, values and attitudes shape understandings of public policy problems and flavour notions of the feasibility of proposed solutions:

A policy paradigm thus informs and holds in place a set of ideas held by relevant policy subsystem members...that shapes the broad goals policy-makers pursue, the way they perceive public problems, and the kinds of solutions they consider for adoption (Howlett and Ramesh 2003: 233).

In order to achieve policy change, the existing policy paradigm must be dismantled before substantive change can occur. Changes that are marginal and incremental and that occur frequently are viewed as “normal”; these occur in closed networks and are dominated by policy monopolies within government (Howlett and Ramesh 2003: 235). Atypical policy change is much less frequent and much more substantial in nature. These changes occur in response to anomalies that the existing policy paradigm can no longer deal with adequately (Howlett and Ramesh 2003: 237).

Hall (1993) looks more closely at the role of the state in policy change, suggesting that there is increased interest in the role of ideas in policy because of a perceived failure of theorists of the state to adequately account for the state’s motivation for its actions, as

expressed in its policies. The concept of state policy-making as social learning has taken hold through researchers' attempts to develop an "alternative conception of the policy process with which to complete their account of policy" (Hall 1993: 275). This concept seems to imply that some actors within the state decide what to do without opposition or input from external actors; in other words, the state acts relatively autonomously in the policy-making process. This is one type of recent theory of the state which he labels "state-centric". Another type is what Hall calls "state-structural", which gives "interest groups, political parties, and other actors outside the state an important role in the policy process" (Hall 1993: 276). In the latter type of theory, how the state is structured, what it has done in the past, and deeper structures of power and dependency, all influence the kind and strength of the demands that these social actors place on the state.

Hall suggests that there are three main factors affecting policy at any particular time. The first is what the policy was at a previous time. The second is that "the key agents pushing forward the learning process are the experts in a given field of policy, either working for the state or advising it from privileged positions at the interface between the bureaucracy and the intellectual enclaves of society" (Hall 1993: 277); politicians play a much smaller role than do the experts. The third is the capacity of the state to act autonomously from exogenous factors. Policy-making is a process that involves three central variables: "the overarching goals that guide policy in a particular field, the techniques or policy instruments used to attain those goals, and the precise settings of those instruments" (Hall 1993: 278).

Hall further identifies three kinds of changes in policy. In the first, the instrument settings or levels are changed to take into account the effects of the policy and any new knowledge which may come to light, while the overall goals and policy instruments remain

the same; this is referred to as a first order change in policy (Hall 1993: 278). A second order change occurs when both the policy instruments and their settings are altered in response to past experience although the overall goals of policy remain the same (Hall 1993: 279). When all three central variables change as a result of reflection on past experience, a third order change occurs; these are major changes in policy.

Hall calls the interpretive framework within which those who make policy work a policy paradigm:

Policy-makers usually work within a framework of ideas and standards that specifies not only the goals of policy and the kind of instruments that can be used to attain them, but also the very nature of the problems they are meant to be addressing. This framework is embedded in the very terminology through which policy-makers communicate about their work. It is influential because so much of it is taken for granted and not amenable to scrutiny as a whole (Hall 1993: 279).

Using Hall's classification of policy changes, his first and second order changes can then be viewed as "normal" policy-making. Third order change is not normal because it is characterized by "radical changes in the overarching terms of policy discourse associated with a 'paradigm shift'". First order changes are viewed as routine incremental decision-making, while second order changes and the development of new policy instruments are more substantial and strategic. Hall finds that third order changes are not yet adequately modelled but, nonetheless, develops some hypotheses about how third order changes in policy come about. Changes in policy paradigms may, for example, be caused by policy failure:

A policy paradigm can be threatened by the appearance of anomalies – developments that are not fully comprehensible within the terms of the paradigm. As anomalies accumulate, ad hoc attempts are made to stretch the terms of the paradigm to cover them, but this gradually undermines the intellectual coherence and precision of the original paradigm. Experiments may be undertaken to deal with the anomalies by adjusting the existing lines of policy, but if the paradigm is incapable of dealing with them, the

experiments will result in policy failures that undermine the authority of the existing paradigm and its advocates even further (Hall 1993: 280).

Third order change is therefore likely to involve the accumulation of anomalies, experimentation with new forms of policy, and policy failures that cause a shift in the locus of authority over policy and initiate a contest between competing paradigms. “It will end only when the supporters of a new paradigm secure positions of authority over policy-making and are able to rearrange the organization and standard operating procedures of the policy process so as to institutionalize the new paradigm” (Hall 1993: 280). Atkinson and Coleman (1996) appear to concur, citing Sabatier’s hypothesis that “...the core of a government’s approach to policy is unlikely to be revised significantly without a change in government that leads to a redistribution of the balance of power among advocacy coalitions within a policy community” (Atkinson and Coleman 1996: 213).

Hall concludes that first and second order changes correspond to the “state-centric” view of social learning, but that third order change corresponds more closely to the “state-structuralist” view: “Only some kinds of social learning seem to take place inside the state itself. The process of learning associated with important third order changes in policy can be a much broader affair subject to powerful influences from society and the political arena” (Hall 1993: 288).

Skogstad (2000) utilizes Hall’s policy paradigm concept to analyze how ideas that have become embedded in institutions shape policy outcomes, noting that “most policy analysts ascribe explanatory power to ideas as they interact with interests and institutions. Thus, ideas become important to policymaking when strategically-placed individuals or groups manipulate them to realize their interests” (Skogstad 2000: 464). Hall (1993) notes that policy paradigms last when their underlying principles are consistent with real world developments and wider

societal normative frameworks. Skogstad (2000) points out that the feedback effect of policies and their related policy instruments also affect the durability of their underlying principles:

Policies have cognitive effects on the strategies of societal actors and their incentives to mobilize and/or build coalitions. An important feedback effect of a policy instrument is whether it promotes solidarity and communal behavior as opposed to organizational fragmentation and particularism among affected citizens. Those policy instruments that create incentives for solidarity among societal groups and for cohesive societal networks to form around policy ideas and policies are more likely to fortify a policy paradigm (Skogstad 2000: 466).

In summary, the literature on the role of ideas and ideology in policy-making would seem to suggest that achieving a major change in policy is difficult and that the dominant paradigm will exert a heavy influence on policy-making.

3.3 Conceptions of Power Relationships

The role of the social economy in public policy is germane to this research because governments have become interested in how social economy organizations can help them to address challenges to their ability to provide goods and services to their constituents. Co-operatives are among the forms of social economy organization that are the subjects of significant research with respect to the role they play in public policy.

Focusing on Quebec, Vaillancourt (2008) addresses the participation of social economy organizations in the policy-making process, differentiating between what they seek and what they achieve in terms of securing a place in the process. He delineates two key concepts in the policy-making process, one being the co-production of public policy and the other its co-construction. The former refers to the participation of stakeholders in civil society and the market in implementing public policy, meaning that the policy is developed

and designed by the state; the latter refers to the participation of stakeholders in the development and design.

Vaillancourt (2008) argues that good public policy requires that stakeholders participate in both the co-production and co-construction processes, with the goal of the democratization of public policy. The co-construction of public policy occurs in several ways: monoconstruction, neoliberal, corporatist, and democratic, solidarity-based. In the first instance, the state constructs public policy on its own and does not involve stakeholders from civil society or the market. In neoliberal construction, “the state is encouraged to construct public policy by co-operating with the private sector, that is, with the dominant socio-economic agents in the market economy” (Vaillancourt 2008: 11). In the corporatist scenario, there is some co-operation between the state and stakeholders but the stakeholders are not equally represented; some are more privileged than others, with the effect that special interests can dominate.

The last instance, which Vaillancourt (2008) favours, is that of democratic, solidarity-based co-construction. This scenario is characterized by four key features. First, the state co-constructs policy in close co-operation with stakeholders from both civil society and the market, with the state remaining the final decision-maker (Vaillancourt 2008: 12). The second key feature is that “democratic co-construction builds on a reform of the state that enables it to become a partner of civil society without for all that ceasing to be a partner of stakeholders from the market economy” (Vaillancourt 2008: 12). The state moves away somewhat from neoliberal co-construction but complements the market economy with the resources of civil society to meet collective interests.

A third feature of democratic, solidarity-based co-construction is that “elected officials establish open, inclusive forms of governance in which dialogue is favoured between the elected officials and the leaders of the participatory democracy” (Vaillancourt 2008:13). The representative form of democracy retains the final decision-making authority, but makes room for stakeholders that have been under-represented in the policy-making process.

A fourth feature represents an ideal of social economy participation in the co-construction of public policy, in which it is enabled to:

...express its voice among those of other stakeholders at the moment when public policy and programs are defined. The issue is that of enabling the social economy to move beyond the status of a mere tool or instrument of the state in the application of public policy plans co-constructed without it. It is that of permitting the establishment of a *partner-type relationship, that is, a non-instrumental relationship*, between the state and the social economy. In a partnership interface, stakeholders from the social economy retain a degree of *autonomy* in relation to the state (Vaillancourt 2008: 13).

Vaillancourt (2008) has thus conceptualized what is, for him, the desired role of social economy organizations in public policy. In this conceptualization, social economy actors want to be and are involved in co-construction, not just co-production of public policy. Social economy organizations have a strong role to play in democratizing the state and enabling under-represented stakeholders to participate, as well as filling gaps left from ongoing adjustment to a post-welfare state.

Vaillancourt’s (2008) conceptualization of two main forms of involvement in the public policy process suggests that in the ideal state of co-construction, the government is assumed to be an open and willing partner to social economy organizations and includes both the market economy and civil society in the design and development of public policy.

The conclusions arising from this conception of the state are that policy-making can be a collaborative process in which all stakeholders have access and participate on the same

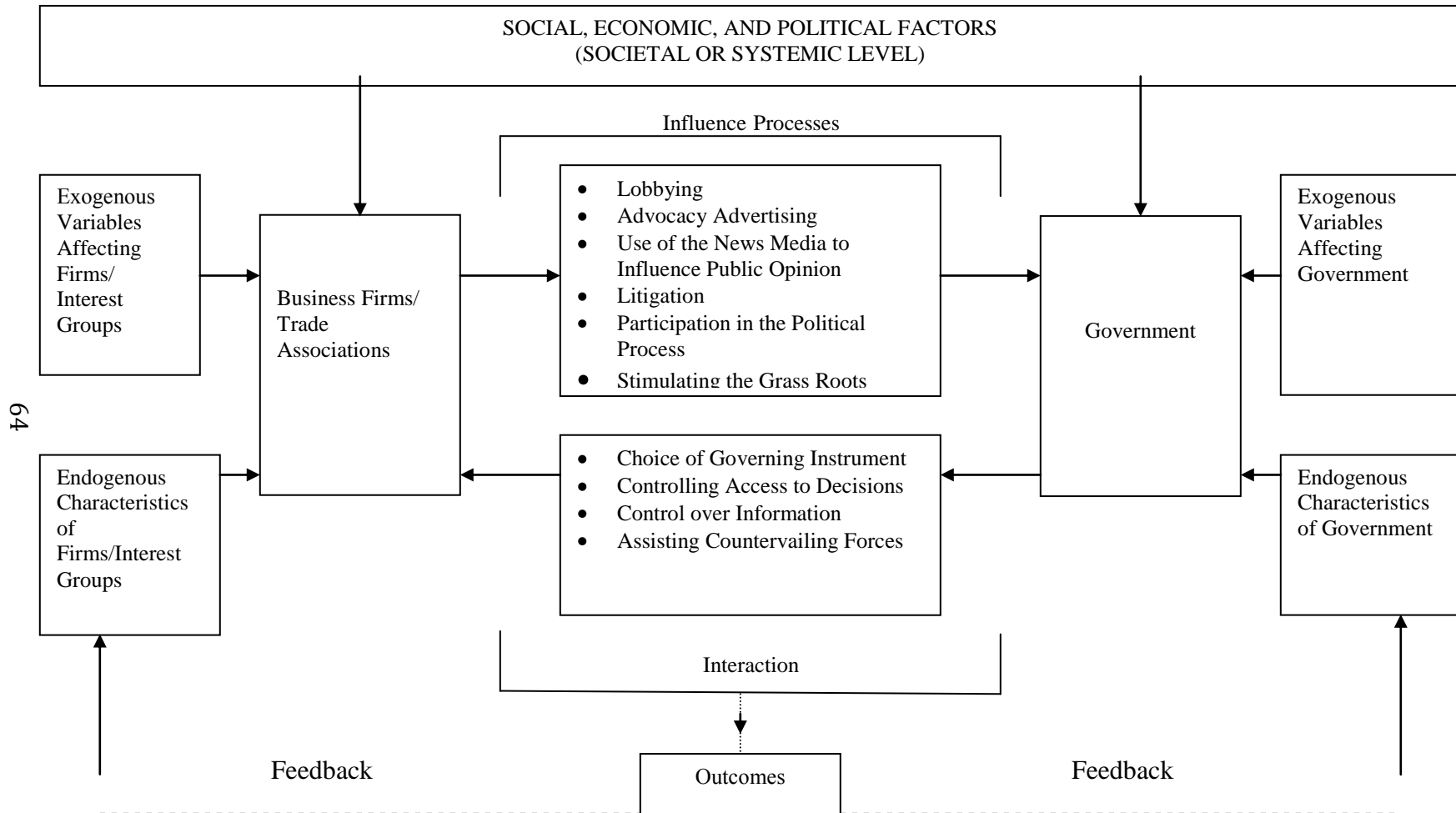
level; government continues to partner with stakeholders from the private sector but also partners with those from the social economy. Further, government decision-makers have established open, inclusive dialogue between themselves and the leaders of social economy organizations, and these organizations are not just instruments of the state in implementing public policy.

3.4 Interest Groups and Public Policy

In contrast to the ideal world that Vaillancourt envisions for social economy organizations, Stanbury (1993) views policy-making as often adversarial. Stanbury's (1993) framework (see Figure One) for understanding the relationship of business with government in Canada is potentially useful for a number of reasons. Stanbury (1993) conceptualizes the relationship between business and government to be frequently adversarial (in the sense that there are winners and losers) with access to and influence over the policy-making process the main goal of business; government's goal is to acquire resources it needs to remain in power. The underlying concepts at play in the relationship are related to public choice theory (Stanbury 1993: 127), with a focus on outcomes – who gets what. The relationship is about the exchange of resources between business and government. While Stanbury talks primarily about business, what he says is relevant to any interest group in the economy or society that can benefit government in some way. This would include social economy organizations and co-operatives.

Figure 2

**A FRAMEWORK FOR UNDERSTANDING
BUSINESS-GOVERNMENT RELATIONS IN CANADA**



Source: Stanbury 1993.

According to Stanbury, political parties in a democracy formulate policies as a means of getting votes. Politicians are assumed to act in a rational, self-interested fashion and “sell” policies for votes. The political party that forms government always acts to maximize the votes it will receive, and therefore targets the interests of the marginal or uncommitted voter because it usually has sufficient information on its supporters. Problems arise for the party in power when it is difficult to ascertain what the interests of the marginal voter are. Information about these interests is costly and difficult to obtain, and frequently political parties lack the resources to acquire it. Because the private sector often possesses the information or the resources to acquire it, it offers these to the party in power in exchange for political favours. Businesses may lobby to secure favourable or fight against unfavourable legislation and regulation; they may seek favourable interpretations of discretionary provisions of existing legislation; and they may provide support to politicians or officials seeking elected or appointed office in expectation of receiving pay, power and prestige in return for future favours (Stanbury 1993).

In Stanbury’s framework, the relationship between business firms/trade associations and government is placed in its social, economic and political context. With respect to the political system, Stanbury finds that one important characteristic is the availability of information about the policy-making process and its outcomes. He states that governments can influence these factors only over the long run and most are outside the influence of business and other interest groups, as are the characteristics of social values in Canada. Doern and Phidd (1992) describe the social values as dominant ideas that can be “part of the agenda of a particular policy field regardless of how they are defined by governments or even in the statutes that create them” (Doern and Phidd 1992:

38). These dominant ideas/values are said to include efficiency, individual liberty, stability of income and of other desired conditions, redistribution and equality, equity, national identity, unity and integration, and regional diversity and sensitivity. Stanbury (1993) notes that interest and lobby groups have to be sensitive to these values/dominant ideas in order to influence government. Of particular interest for this study is the importance of traditions, symbols, institutions and collective memory in national identity. Over time, Medicare has become a symbol of the Canadian national identity (Commission on the Future of Health Care in Canada, November 2002); it is a way that Canadians distinguish themselves from Americans, for instance.

The processes utilized by both parties to influence each other are of particular importance in determining the outcomes of the relationship. Stanbury (1993) describes the relationship between business and government as dynamic and complex. Over time, the balance of power can shift between the parties and both parties have to address a wide range of issues in different policy areas. The process is serial in that “the game has an infinite number of rounds (or innings)”. The outcomes of the rounds or innings are often inconclusive as far as what constitutes a win or a loss for either party. Finally, “...the parties are highly interdependent. Society requires both business and government as institutions, and it is necessary that they relate quite closely to each other” (Stanbury 1993: 18).

The characteristics Stanbury (1993) identifies that are most relevant to this study are governments’ control over information, access to the policy-making process, and resources that are needed by lobby or advocacy groups. Although political parties need information from business to secure power, when they form government, they can and do

exercise control over information, which can result in information asymmetry for business. Lack of access to the policy-making process can result in a group or association's failure to secure the resources necessary to fulfil their mandate. With respect to groups and associations, lack of cohesion among members can also impede their efforts.

Stanbury (1993) suggests that outcomes can be evaluated in terms of their efficiency, dynamism, openness, maintenance of individual freedom and degree of healthy rivalry. Dynamism refers to the ability of the relationship to change over time in response to exogenous factors affecting either or both parties to the relationship. When Stanbury (1993) speaks of openness, what he means is that the relationship between business and the government should be "well and widely understood", capable of accommodating new or emerging interests "so that change can occur without severe discontinuities". The evaluation criteria, maintenance of individual freedom, relates to how government intervention affects individuals' choices. It speaks to the values underlying the political system and where the balance of power lies. Stanbury (1993) notes that "persistent dominance by any interest group, including government, [must] be avoided if we are to aspire to a genuinely pluralist, democratic society" (Stanbury 1993: 41).

Healthy rivalry refers to the dynamic tension between the parties to a relationship that can result in the relationship's evolution and adaptability to changes in the exogenous and endogenous characteristics of the parties, as well as to the broader social, political and economic environment.

Finally, Stanbury (1993: 42) sets out four categories of outcomes in the relationship between business and government:

- Business dominates government
- Government dominates business
- Social gridlock
- Win some, lose some.

When business dominates government, it generally gets what it wants; this includes a wide range of government responses to business demands as long as those responses benefit business. When government dominates business, it places a higher priority on other groups in society to the detriment of business. Stanbury (1993) describes social gridlock being like “an institutional sclerosis” which occurs when all of the actors can effectively neutralize the others; in such cases, “positive, creative forces cannot generate the growth and dynamism possible in more open societies (Stanbury 1993: 423). In the “win some, lose some” category of outcomes, business does influence government some of the time, but other interest groups may influence government through their own lobbying and advocacy efforts.

In summary, Stanbury’s (1993) framework is based on public choice theory, where government seeks to gain and retain political power as the governing party and business seeks a favourable legislative and regulatory environment. Each has something the other wants, resulting in the exchange of resources; the more valuable the resources that business can offer to government, the more power business will hold in the relationship. Moreover, the relationship between business and government is primarily adversarial.

Stanbury’s framework is useful for the purposes of this thesis as a heuristic device to categorize the findings obtained through key informant interviews. It provides a

means to organize the findings to identify key factors in the relationship between the Community Clinics and the government, as mediated by the medical establishment (see Chapter Five). The framework also provides a means of thinking about the constraints that exist, the influence processes used by the parties to the relationship, the impacts of the instruments chosen by the government in its interaction with the Clinics, and differences within the parties to the relationship.

Because Stanbury's framework focuses on business-government relations in Canada, it is necessary to make some adaptations more appropriate for the study of the relationship between the Community Clinics and the provincial government in the context of primary health care delivery. The framework does not address the degree of internal cohesion within the government; in the primary health care context of Saskatchewan, the elected politicians, Department of Health officials and Health Region officials are all actors that often have differing views. The medical profession is also an actor possessing considerable resources and influence in this context. The framework requires that the medical profession's influence processes be taken into account.

The exogenous variables and endogenous characteristics of business trade associations and lobby groups must also be adapted to better represent those of the Community Clinics. Indeed, Stanbury's interpretation of these terms differs from what they are normally understood to mean. For instance, he considers member characteristics of business associations to be an exogenous variable, not an endogenous characteristic.

3.5 Summary

The preceding sections have proposed three different ways of conceptualizing the relationship between the state and particular interest groups with respect to policy-

making and policy change: Stanbury's conceptualization of business-government relations as adversarial with the exchange of resources the prize; Hall, Howlett and Ramesh, and Doern and Phidd's conceptualization of how policy change occurs and the conditions necessary to achieve it; and, Vaillancourt's conceptualization of an ideal situation in which social economy organizations are equal partners in the co-construction of public policy.

The premise underlying Stanbury's (1993) framework is that there are winners and losers, not that the parties are hostile to one another; nonetheless, the outcomes are frequently win-lose, rather than win-win. When interest groups do get what they want from government in the form of policy concessions – i.e. when they “win” – it is usually because they possess power in the form of resources that the government wants. There does not appear to be much room for collaboration in Stanbury's conceptualization of the relationship between interest groups and government.

The other two models do provide room for collaboration between the parties involved. Vaillancourt in particular regards both parties as equals in spite of the differences in the resources, and therefore power, that each might possess, thus presenting the possibility of a more collaborative relationship.

In summary, there are many conceptualizations of what public policy is and how it is developed. There are many different actors with different ideas, values and goals; many instruments through which public policy can be effected; many forms that public policy can take; and, numerous constraints to the process. Relationships among the actors, the issues and the processes are frequently complex. Interest groups outside of government often find that achieving their goals in this environment is highly

challenging. The literature on the role of ideas and ideology in policy-making would seem to suggest that achieving a major change in policy is difficult and that the dominant paradigm will exert a heavy influence on policy-making.

The literature on conceptualizing power relationships suggests that policy-making can be a collaborative process in which all stakeholders have access and participate on the same level; government continues to partner with stakeholders from the private sector but also partners with those from the social economy. Further, government decision-makers have established open, inclusive dialogue between themselves and the leaders of social economy organizations, and these organizations are not just instruments of the state in implementing public policy.

The literature on business and public policy suggests that government seeks to gain and retain political power as the governing party and business seeks a favourable legislative and regulatory environment. Each has something the other wants, resulting in the exchange of resources; the more valuable the resources that business can offer to government, the more power business will hold in the relationship. Moreover, the relationship between business and government is primarily adversarial.

Based on the concepts drawn from these streams of the literature, the following is anticipated:

3.5.1 Proposition Three:

Achieving major changes in government policy towards co-operatives will be difficult, unless co-operatives have some resources to offer to government. The more valuable the resources that co-operatives can offer to government, the more power co-operatives will hold in the relationship.

3.5.2 Proposition Four:

Co-operatives will expect equitable relationships with government and the co-construction of public policy as it affects them, but will not be successful. The underlying ideas and ideologies of the government and other key actors in a policy field will often prevent this.

In the chapter that follows, the case of Saskatchewan's co-operative Community Clinics is presented, with findings from the transcripts of the key informant interviews conducted for this study. In Chapter Five, the findings are assessed against the propositions identified here and in Chapter Two.

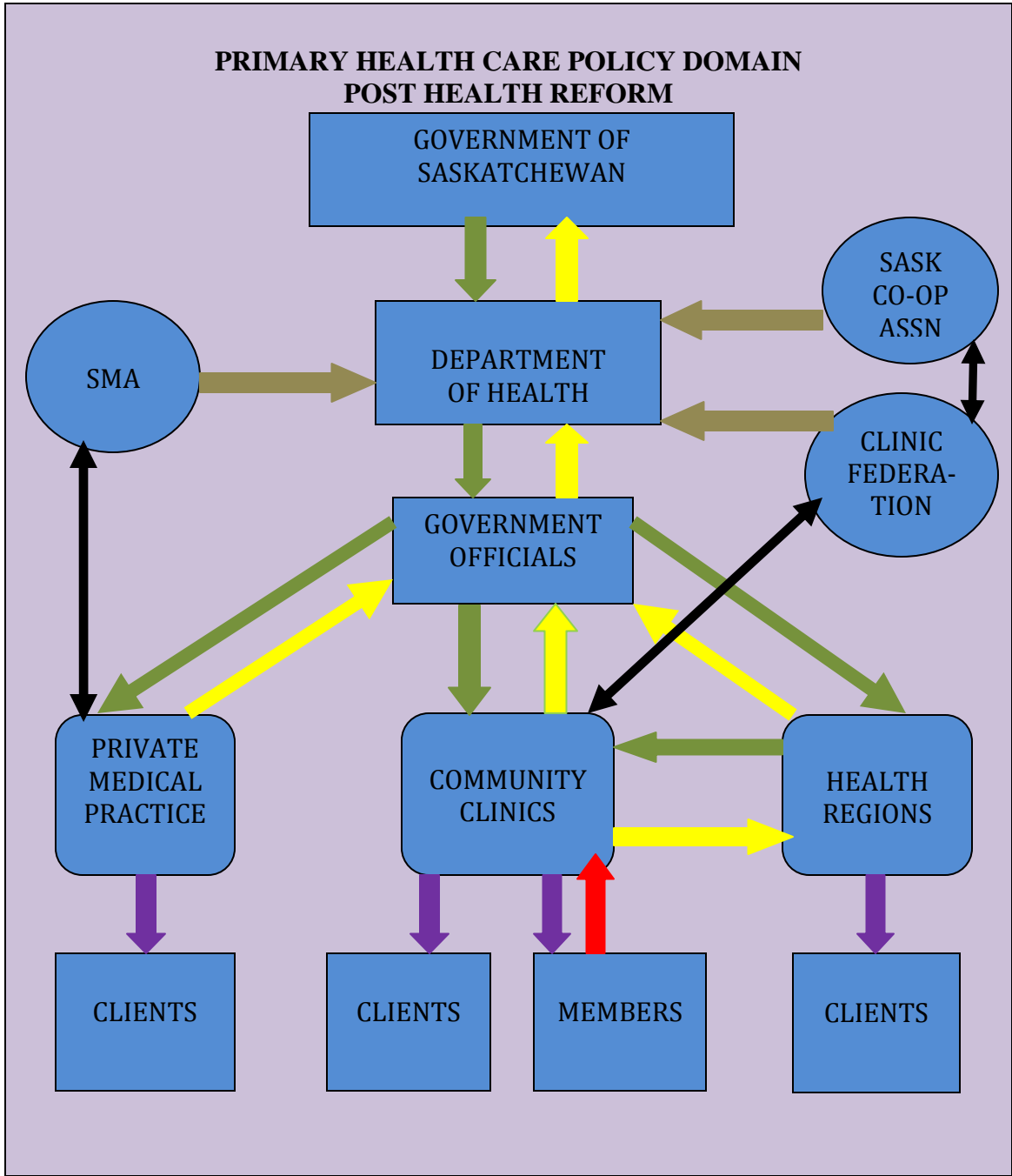
CHAPTER FOUR: RESEARCH APPROACH AND FINDINGS

4.0 Introduction

The purpose of this chapter is to present a case study of three of Saskatchewan's co-operative Community Clinics. Fairbairn (1997) cites co-operatives as being the "most precisely defined" entities among the social economy organizations in Canada and as playing a key role in the establishment of the country's public health care system: "The development of 'community clinics' was an integral part of the development of the Medicare program" (Fairbairn 1997: 6). Not only were the Community Clinics in Saskatchewan developed as co-operatives to provide medical services in the event of a doctors' strike, they were developed on principles that have become the core of Medicare (Rands 1994; Johnson 2004). When Premier Tommy Douglas announced his intention to implement a medical insurance plan for residents of Saskatchewan, he said that it would be based on a pre-payment principle, universal coverage, high quality service, administration by the Department of Public Health or an agency responsible to government, and acceptability to both those providing and those receiving the services (Tollefson 1963: 45). Over time, these principles have evolved to those in the current federal legislation on Medicare (see Appendix Seven.).

All of this seems to suggest that the Community Clinics, in some ways, have been very successful and influential. Yet, they still struggle to find a place and play a stronger role in the delivery of primary health care in Saskatchewan today. The policy environment in which they do so is complicated, with a number of highly complex relationships at play. The Community Clinics thus represent a strategic test of the propositions set out in Chapters Two and Three. They are not the only valid test because

the experience of other co-operatives could be tested, but they are important because of their role in the development of Medicare and their uniqueness as social economy organizations in primary health care delivery.



Funding
 Accountability
 Services
 Ownership
 Influence
 Advocacy

Figure 3 - Prepared by author

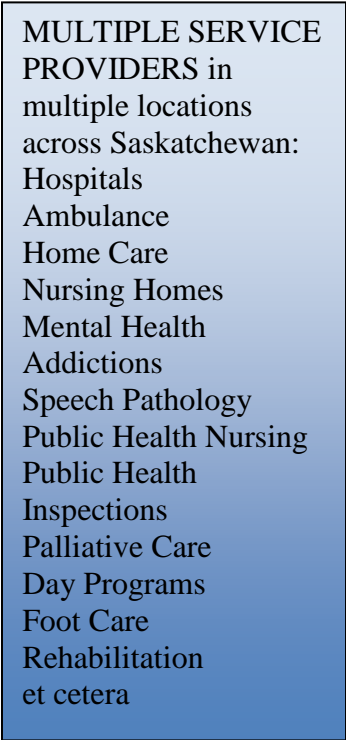
The key players in the health care policy domain in Saskatchewan are the government, comprised of elected officials, departmental officials and the health regions, the Community Clinics, together with their Federation and members, and the medical establishment (see Figure 3 on page 74). This depiction excludes other actors not directly involved in the relationship between the government and the Community Clinics. The flows of funding, accountability, service provision, influence, advocacy organizations and ownership are portrayed.

The figure shows the Clinics as having a direct relationship with the Health Regions. The Clinics are expected to co-ordinate their programs and services with those of the Health Regions; also, any additional funds they require for new initiatives must be obtained from the Health Regions. The elected and departmental officials of the government have a direct relationship with the Health Regions because the Health Regions are the government's chosen structure to deliver institutional services in the province (*An Act respecting Regional Health Services*, Chapter R-8.2 of The Statutes of Saskatchewan, 2002). At the same time, there are relationships between the elected officials and the Community Clinics, and between departmental officials and the Community Clinics. These relationships differ in important ways, which are identified in the findings in this study.

The Saskatchewan Community Health Co-operative Federation represents the Clinics' interests to government; thus a direct relationship between the government and the Federation is shown. The co-operative movement also lobbies government on behalf of co-operative interests in general in the province. The Federation is a member of the Saskatchewan Co-operative Association (Saskatchewan Co-operative Association 2006-

07 Annual Report); thus the Clinics have a relationship to the Federation. In this diagram, the individual Community Clinics include the Clinics' boards and administrators. Clinic members are the ultimate groups affected by the relationship between the Clinics and the government. It is important to note that the Clinics' members are the only group with an ownership relationship with the organization providing them with primary health care services. This is the key way in which the Clinics differentiate themselves from private medical practice and the Health Regions; members are not just clients, they are owners.

It is also important to note that prior to health reform, there were hundreds of organizations across the province delivering different components of health care. In place of the Health Regions in Figure 3 (page 75) would be the following:



MULTIPLE SERVICE PROVIDERS in multiple locations across Saskatchewan:
Hospitals
Ambulance
Home Care
Nursing Homes
Mental Health
Addictions
Speech Pathology
Public Health Nursing
Public Health
Inspections
Palliative Care
Day Programs
Foot Care
Rehabilitation
et cetera

Post health reform, the Health Regions represent another actor in the primary health care policy domain that the Clinics must deal with and work through; this diminishes the strength of the relationship they previously had with department officials and elected politicians, as discussed in Chapter Five.

The medical establishment is a key player in the health care policy domain through the Saskatchewan Medical Association (SMA). Although there is no direct relationship between the medical establishment and the Community Clinics, it nonetheless has considerable influence over the policy environment regarding the delivery of health care in the province. The SMA speaks for and lobbies on behalf of physicians; it was opposed to the Community Clinics when they were created at the time of the doctors' strike (Tollefson 1963; Badgley and Wolfe 1967; Rands 1994) and they appear to remain opposed today, especially with regard to maintaining fee-for-service remuneration. Because of its influence, the medical establishment is an important mediator in the relationship between the Community Clinics and the state.

The health care policy domain is comprised of a large number of actors within a complex, multi-layered network of relationships. This is the policy environment in which the Community Clinics seek to negotiate their place at the policy-making table. Within this context, the case study of the Community Clinics follows.

In this chapter, the rationale for case study research is discussed first; the data collection methodology used for this case study is then described, and the specific methodology utilized to analyze the key informant interview transcripts is explained. Next, information on each Community Clinic, information about how it is organized and run, its budget, programs and services offered, board composition, staff complement, and

vision, mission and values is provided. The chapter then sets out the findings from the data about the relationships between the co-operative Community Clinics and elected officials of the government, departmental officials and the medical profession.

4.1 Methodology: Case Study Research

The methodology chosen for this research is empirical in nature, with the need and intent to explore the relatively large number of concepts contained in Stanbury's framework. The complexity of the three-way relationship between the Community Clinics and the government and departmental officials, as mediated by the medical establishment argues for a case study approach using qualitative methods, including documentary sources and in-depth interviews with key informants. A comparative method is adopted to examine the differences and similarities of the three Community Clinics with respect to the propositions. The Community Clinics are unique in the co-operative sector in Saskatchewan in that they receive the majority of their funding from the government. Yet there are sufficient differences among the three Clinics to justify studying all three instead of just one, as is normally done with a strategic or critical case. One has been the nexus of political action and lobbying, one has avoided a role as political advocate, and one occupies a middle ground in terms of political activism. Examining the three provides a broader field for developing and testing theory.

A case study approach allows the researcher to obtain the perspectives of the participants involved in the organizations today and historically; some of the participants have had a direct role to play in shaping the relationship between the Community Clinics and the government. Although the Medicare crisis occurred over forty years ago, there

are still people around today who remember it and speak of it as though it was only yesterday. It is very much alive in the minds of these people. In the years since, Clinic advocates and government officials, whether elected or appointed, have developed very different beliefs about the relationship. Their experiences and perspectives could not be captured adequately through quantitative methods.

According to Yin (2003), a case study approach is preferred when examining contemporary events and when the relevant behaviours cannot be manipulated by the researcher. Its utilization is appropriate when complex phenomena need to be understood. It “allows an investigation to retain the holistic and meaningful characteristics of real-life events” and can accommodate a full variety of evidence, including documents, artifacts, interviews and observations beyond what may be available (or admissible) with a conventional historical study (Yin 2003: 8).

The case study is one method utilized in qualitative research (Gall et al. 1996); other methods include ethnography, grounded theory (Glaser and Strauss 1967), and action or participatory research. It could be called an “interdisciplinary” method because of its use in a number of disciplines, including management studies and organizational theory, education, sociology, and political studies. Graduate schools of business commonly utilize the case study as a basic tool of teaching.³

Use of the case study approach has its proponents and its detractors. As a proponent, Schell (1992) regards the case study as:

...unparalleled for its ability to consider a single or complex research questions within an environment rich with contextual variables.
Observation, experiments, surveys and secondary information (archival)

³ See, for instance, Leenders, Leenders and Erskine 2001 on the use of cases at the Richard Ivey School of Business at the University of Western Ontario and the website of the Harvard School of Business: <http://www.hbs.edu/case>.

have the advantage of producing sets of independent and dependent variables suitable for quantitative analysis: The case study is best suited to considering the how and why questions, or when the investigator has little control over events (Schell 1992: n.p.).

The case study approach can accommodate a broader range of evidence, building a chain of evidence which gives this kind of research greater validity.

Detractors of case study approach point out both practical and more abstract concerns. Practical concerns include the highly labour-intensive nature of data collection, of organizing and reviewing large volumes of field notes, and of analyzing the data and then writing it up so that it is “systematically comparable” with data collected using other methods. Related to this concern is the amount of time case study preparation can take, which can result in “massive, unreadable documents or report only the researchers conclusions” (Schell 1992).

The risk of researcher bias is also a concern; this methodology is frequently regarded as being more subject to researcher bias than use of other strategies. Further, “...there are fewer conventions the researcher can rely upon to defend him/her self against self-delusion or the presentation of ‘unreliable’ or ‘invalid’ conclusions” (Miles 1979 quoted in Schell 1992: n.p.). Schell (1992) further notes that critics claim that case studies do not provide an adequate basis for scientific generalization, and that the case study methodology is not well formulated because of a “lack of rigour in method and execution”. Quantitative methods such as experimentation are viewed as more rigorous and therefore more valid and reliable. However, these problems with the case study approach “are not innate, but instead represent opportunities for development within the research strategy, or even more importantly, recognition of methodological constructs which are already known” (Schell 1992: n.p.). Quantitative methods alone

may not be sufficiently flexible in design and application to be sensitive to the complexities of social phenomena; qualitative methods are more sensitive because design and application can evolve during the research to accommodate the complexities of the phenomenon under study (Dube and Pare 2001).

In this study, efforts to minimize researcher bias were made in several ways. Large sections of the transcripts were reproduced to demonstrate that the informants' views were being interpreted accurately. Pains were taken to ensure that attention was given to minority voices and positions, and similarly, that outliers and the unexpected were identified and explained where they were found. A multi-layered comparative approach was used to capture the differences among the three Clinics and the differing perspectives held by different types of informants.

The knowledge and experience gained from being an insider in both the Clinic world and the policy-making world in the provincial government made me a strong candidate for doing this research and offered distinct advantages. Having both perspectives minimized the possibility that one would dominate over the other. In addition, the past involvement of three of the Student Advisory Committee members as board members of the same Community Clinic meant that they possessed intimate knowledge its operations, providing another check on the accuracy of the interpretations presented here. Insider experience and knowledge also facilitated access to the different types of informants interviewed for this study.

4.1.1 Summary

In doing the present research, surveys and other quantitative methods were not considered to be adequate to examine the relationship and other behaviours under study. There were too few informants and the concepts too numerous and complex to use quantitative methods. Past research on the role of ideas in policy-making appears to have utilized historical analysis and case study approaches (Hall 1993; Skogstad 2005). Case analysis allows deeper exploration of the motivations and actions of the actors in the case, and is useful in theory development because it allows investigation of the actors' responses to decisions made by other actors (Westgren and Zering 1998: 3). It is of particular value in instances when the research question does not lend itself to statistical (quantitative) analysis (Gall et al 1996; Westgren and Zering 1998), as is the instance in this research.

4.2 Data Collection Method

The data that forms the basis for the case of the Community Clinics in this research is derived mainly from primary sources such as the Clinics' own documents (annual reports, newsletters, Clinic histories, submissions to government commissions, etc.), key informant interviews, as well as secondary accounts (a few monographs on the history of Medicare, journal and newspaper articles, monographs on the history of the Douglas and Blakeney governments, etc.) As Yin (2003) notes, multiple sources of evidence are required to produce high quality case studies, with interviews being one of the most important sources.

The key informant interviews were important for providing historical interpretation of events and insight into the motivations of the relevant actors. In order to facilitate the research, a letter was sent in advance of scheduling the interviews to gain the permission of senior officials to interview appropriate staff members in their organizations (See Appendix One). None of the key informants approached for an interview refused to participate.

The interviews were structured into two groupings, one for informants directly involved in the Community Clinics (past and present Clinic administrators, board chairs, and staff) and the other for informants who have or who have had a role in establishing the policy and institutional environment in which the Clinics operate (past and present politicians, Department of Health officials, and Health Region officials) (see Appendices Two and Three). One health care consultant was also interviewed utilizing the interview questions prepared for the latter group.

Table 1–Key Informant Interviews

Key Informant Groups	Clinic	Politicians	Govt. Officials	Health Regions	Others
Number Inter-viewed	6	4	3	6	2

The selection of key informants for this research was limited by the small number of Community Clinics in Saskatchewan. Because there are only five existing community health care co-operatives in the province, the pool of potential informants for this research was quite small, offering a maximum of five Community Clinic administrators and five chairs of the boards of directors. Ultimately, this pool was reduced because one Community Clinic had amalgamated with the Health Region and another operated on a

different funding basis. The administrators and board chairs are the key informants from the Community Clinics with the most exposure to and contact with the policy-making process. Interviews were also conducted with key elected and appointed Health Region officials, Department of Health officials, health care consultants, and a number of provincial politicians who were in office during the period of time being studied.

The interview questions were informed by the conceptual tools reviewed and were designed to engage the participants in a fuller exploration of their own past experiences and practices. Questions related to the role of co-operatives as social economy organizations, their participation in the public policy process, and government's understanding and treatment of the Community Clinics solicited key informants' views on the role that the Community Clinics play in health care in Saskatchewan, the advantages and disadvantages of the co-operative model of primary health care delivery, how well this model has addressed public policy objectives, how the relationship between the Community Clinics should be characterized, whether politicians viewed the Community Clinics differently from government officials, how successful the Community Clinics' lobbying efforts have been, and how well the government has met the needs of the Community Clinics. Questions related to the conditions necessary for policy change solicited key informants' views on whether the relationship between the Community Clinics and the government has changed over time, whether the political cycle has affected the relationship, the challenges and opportunities the Community Clinics face, and the future directions they may take. Responses addressed all of the components of the framework elaborated by Stanbury (1993).

The interviews were semi-structured; questions were open-ended in order to solicit informants' views as well as more basic "factual" information. Individual interviews were audio-taped to ensure that the responses were accurately captured. Notes were also taken during the interviews as a secondary means to record the informants' thoughts.

The audiotapes were transcribed into Word documents to form a transcript database in Microsoft Word. The transcripts were not edited to correct grammar; meaning or sentence structure; the voice and words of the key informants were respected. The interviews were transcribed by a staff member of the Centre for the Study of Co-operatives under the supervision of the researcher. The staff member signed a confidentiality agreement with respect to the transcripts.

The interviews were conducted over approximately seven months. Individual interviews generally took between 60 and 90 minutes to conduct. Twenty-one key informants were interviewed for this research, providing the major data source. Two key informants participated in the same interview, resulting in twenty transcripts. Eighteen of the twenty interviews were conducted in person by the researcher. Two were conducted by telephone.

Following transcription, the relevant transcripts were forwarded to each informant for their review and editing. The informants had the option of withdrawing from the research at any time during the interview and transcription process; none of the selected informants chose to withdraw. Informants returned their revised transcripts along with a signed Interview Transcript Release Form. Their revisions were incorporated into the digital version in the transcript database. All of informants chose to remain anonymous;

none of their comments were attributed to them by name. Ensuring anonymity allowed informants to share their views more freely than they might have otherwise. All transcripts were assigned to a double numbering system to further ensure anonymity.

An ethics approval process was undertaken in keeping with the University of Saskatchewan's Ethics Review policies and procedures. An application for approval was submitted in September 2005 and approval was received on October 11, 2005. The application included questions for semi-structured interviews with key informants from the Clinics, as well as questions for non-Clinic participants including former provincial government politicians, Department of Health officials, Health Region officials (elected and senior management), health sector consultants and other related informants (see Appendices Four and Five).

4.3 Data Analysis Method

The analysis of the field interview data was based in part on the application of a content analysis software package to the transcripts of the key informant interviews, and the systematic review of secondary sources including annual reports and newsletters published by the Clinics, as well as the other literature on the Clinics. Qualitative data analysis (QDA) software is increasingly utilized by researchers undertaking studies which involve large amounts of text, for instance, transcripts from key informant interviews. Its use moderates both the labour-intensiveness of data analysis and the risk of researcher bias. The QDA software was used for both of these purposes in this study. It provided a useful starting point for the organization of the transcripts such that the aspects of the relationships under study could be identified and then analyzed. The QDA

package used in this research is Weft QDA (Fenton 2006), which was chosen because of its ease of use by a researcher without previous QDA experience; it is also available free of charge. Its use enabled the researcher to analyze hundreds of pages of transcripts from the key informant interviews.

Respondents were grouped into several categories; these included clinic informants, politicians, government officials, health region informants, and other informants. The data analysis process began with initial readings of the transcripts and the field notes, as well as listening to the audiotapes. Search terms were then developed for each component of Stanbury's framework and the transcripts database was queried systematically for occurrences of these terms. The framework provides a means of thinking about the constraints that exist, the influence processes used by the parties to the relationship, the impacts of the instruments chosen by the government in its interaction with the Clinics, and differences within the parties to the relationship.

The Weft software provided for a search of the entire database by each group of informants. Search results were captured in two forms: tables showing coding statistics cross-tabulated by informant group; the second the relevant text by individual informant. The latter resulted in a new database where the responses of informants could be sorted and compared by each search term. This facilitated identification of similarities and differences among informants and informant groups. Relevant quotes specific to the search terms were also identified and incorporated into the discussion.

The findings are organized and presented in a format corresponding to elements of the adapted version of Stanbury's framework, beginning with the endogenous characteristics of the Community Clinics. The analysis then proceeds through the

exogenous variables affecting the Community Clinics, the endogenous characteristics of the government and the exogenous variables affecting it, the interaction between the Community Clinics and the government, and the influence processes at play in their relationship.

Stanbury's framework does not distinguish between politicians, government officials and the Health Regions. However, the adapted version does address the differences among these three groups, and the differences between the Community Clinics and these groups are identified in the discussion. As noted previously, Stanbury's use of "endogenous" and "exogenous" differ from what is normally meant by these terms. For instance, he views membership characteristics as an exogenous factor, not endogenous. Although his framework is used to organize the transcript data, wherever possible, the language of the data itself is used to clarify his categories.

The term "Community Clinic" itself has different meanings. It can refer to a distinctive organizational form with a name that by law can only be used by the Community Clinics; it can also refer to the Community Clinics being studied in this research, either as "the Clinic" to refer to an individual clinic, or "the Clinics" to refer to all three. Generally, if the findings or discussion are applicable to all three, the plural form ("the Clinics") will be used; if the findings or discussion are applicable to only one Clinic, the singular form ("the Clinic") will be used. If the distinctive organizational form is discussed, it will be as the co-operative community clinic model.

CHAPTER FIVE: CASE STUDY AND FINDINGS FROM THE DATA

5.1 Co-operative Community Clinic A

Clinic A is one of the first to be established in Saskatchewan. It was incorporated under *The Mutual Medical and Hospital Benefits Association Act*, but has changed its incorporation to fall under *The Co-operatives Act, 1996*. Because it was the last organization still incorporated under *The Mutual Medical and Hospital Benefits Association Act*, the Department of Health plans to repeal this act.

Clinic A is governed by a twelve-member Board of Directors, with an Executive Committee and a number of subcommittees to deal with specific aspects of the enterprise. These include: Operations, Strategic Planning, Member Services, Political and Social Action, and Primary Health Care. The Board's composition allows for representation from Clinic A's medical staff and members of the union of non-medical staff. The head of the medical group reports directly to the Board of Directors. Clinic A also has an Advocacy Network which provides members with "organized information and support so they will be able to act in an informed way to defend and promote publicly-funded health care and to support other health-related actions". An administrator who reports to the board oversees the operations of Clinic A.

Clinic A has approximately 11,000 members, but people do not need to be members to use the services of the Clinic. It is estimated that an additional 14,000 people are served. Clinic A employs 125 full and part time staff and representing 12 disciplines involved in providing interdisciplinary primary health care. They work out of three sites in their urban location and draw some members and patients from surrounding areas.

Clinic A also provides physician services to a neighbouring small town.

Clinic A's annual operating budget is approximately \$8.25 million, the majority of which comes from the Department of Health. Additional funds are received from the federal government, fee-for-service, and member fees. Grant funding from the federal government and other sources is also used to undertake special projects and pilot new services and programs. Some of Clinic A's programs are funded through donations received by a charitable foundation established specifically for this purpose. Individuals pay \$15 and a family \$30 for a lifetime membership. Members are also asked to contribute on an annual basis. Member benefits include reduced rates on dispensing fees for prescription drugs and free delivery of prescriptions, as well as coverage for non-insured medicals. Member benefits also include eligibility to run for the Board of Directors, and to serve on committees and volunteer. Members receive Clinic A's newsletter and are invited to volunteer for various projects and roles.

The vision of Clinic A is:

Healthy individuals in a healthy community. Our vision is a world where communities, families and individuals experience optimal conditions for health through all stages of life, actively pursue and manage their own health, and are supported by a publicly administered health care system offering high quality primary health services provided by an integrated and innovative health care team (Clinic A website).

Its mission is to provide excellence in primary health care. Clinic A also sets out a statement of values to which it adheres, as follows:

We believe:

- People who use our health services should help decide what our services will be and how our services will be offered to the community.
- People's health needs are best met by an active partnership

between the people who use health services and people who offer them.

- Co-operative community clinics, run by the people from the community, are an ideal way to provide health services.
- Health care services people need should be: universal; accessible; comprehensive; portable; and publicly administered.
- When health care providers work together as a team, our users benefit.
- People have a responsibility and a right to support and control their own health. Our role is to support them to act on their responsibility and right.
- Social and economic factors such as racism and poverty can profoundly compromise the health of the people we serve. We will act socially and politically to eliminate the negative effects of these factors on people's health.
- People should have equal opportunity to achieve health and well-being. They should also have equal opportunity to receive health services according to their needs.
- We must make responsible use of the public and member funds provided to support our services by ensuring they are used effectively, economically, and efficiently.
- We need to dedicate ourselves to ensuring our services are accessible to all individuals and groups in need of them in our community (Clinic A website).

Clinic A's services and programs include: community mental health nursing; counselling; laboratory, electrocardiogram and x-ray facilities; family physicians; a health information centre; member relations; nursing; nutrition services; occupational and physical therapy; and a pharmacy.

Clinic A has numerous partnerships to provide programs and services in its community, particularly marginalized populations who may have difficulty accessing care. Examples include a medical student-run clinic at Clinic A's inner city clinic site, a home visiting program for high-risk families in inner city neighbourhoods, a community kitchen to help people learn how to prepare nutritious meals at reasonable cost, an Aboriginal seniors' program, and a diabetes program for at-risk Aboriginals. Clinic A is

the only Community Clinic among the three being studied that has signed an agreement with its Health Region to co-operate and to co-ordinate delivery of primary health care services (see Appendix Nine).

Clinic A can be characterized as the most politically active of the three, lobbying not only for itself, but also for all of the Community Clinics, the co-operative model of primary health care delivery and for Medicare. Clinic A has attracted the attention of health care administrators, practitioners and researchers from around the world, and continues to host delegations that come to learn about the model. Outside of the province and the country, Saskatchewan is recognized as having a positive and effective model for consumer-owned and operated primary health care.

5.2 Co-operative Community Clinic B

Clinic B is incorporated under *The Co-operatives Act, 1996* and is governed by a twelve-member board, with Finance, Membership and Publicity, and Education and New Programs committees. Clinic B's physicians report to the board through a medical co-ordinator who is a doctor. Its mission statement is:

We are a health co-operative which is proactive in providing comprehensive health, social and educational services to members, patients and clients from [our community] and district. Our mutual goal is the creation of a healthy community (Clinic B website)

Clinic B's vision statement is:

Working co-operatively for a healthy community (Clinic B website).

Clinic B provides the following services: family physicians, nurse practitioner, expanded nursing, laboratory, exercise specialist, counselling services, nutrition, optometry, X-Ray/ECG, health information centre, menopause resource centre, blood

glucose monitoring, and 24 Hour emergency call service.

Clinic B offers a lifetime membership for the cost of \$5 per person or \$10 per family. This lifetime membership gives members the right to vote at members' meetings, i.e. Annual General Meeting, run for the Board of Directors, sit on any of Clinic B's committees and receive Clinic B's newsletter.

A reminder notice is sent on members' anniversary date letting them know that the special benefits portion of the membership is about to lapse, and giving them the opportunity to renew so as to continue receiving the special benefits. In the first year of membership, members pay only the lifetime membership fee; the Annual Special Benefits portion is waived and members receive all benefits for \$5 if single, or \$10 for a family.

Like Clinic A, Clinic B has a fund to which tax-deductible donations can be given. Contributions to the fund enable Clinic B to improve education, prevention, and health promotion programs and purchase needed medical equipment. Clinic B's informants noted that the efforts of volunteers to fundraise for Clinic B were very important in supplementing the funding it receives from the provincial government. Additional funds in the form of grants are also obtained from other federal and provincial sources. These are critical to keeping the Clinic solvent.

Also like Clinic A, Clinic B has many partnerships in the community to provide services and programs, and also relies on volunteers to help deliver these. Examples include support for people with Fetal Alcohol Spectrum Disorder, day care centre to help young mothers stay in school, and services for new immigrants and refugees, including medical exams and treatment for Post Traumatic Stress Disorder.

Clinic B's budget for 2005-06 was approximately \$3.1 million. It has 51 people on staff, with 3,200 active members and 14,689 on its total membership list. Like Clinic A, it is located in a large urban centre. It undertakes some lobbying and advocacy activity, but not to the same extent as Clinic A.

5.3 Co-operative Community Clinic C

Clinic C is also located in an inner-city neighbourhood in a large urban centre in Saskatchewan. It has 16,000 clients and nearly 7,000 active members. Clinic C employs 52 full time staff and has an annual budget of over \$4 million. Most of its revenue is received from the Department of Health, as is the revenue of the other two Clinics, A and B.

Clinic C is incorporated under *The Co-operatives Act, 1996*. Its mission is:

The [community] Co-operative Health Centre is a primary health care provider. We enable our clients by providing preventative, health promotion, supportive and curative health services.

Its values are:

We believe ...

Health care for all should be universal, accessible, comprehensive, portable and publicly funded.

Every individual is to be treated with compassion, respect and dignity.

Interdisciplinary health care teams are an integral part of health services delivery.

Primary health care provision includes cooperation and partnerships with the whole community.

In demonstrating integrity, commitment and accountability to our clients.

In striving for continuous quality improvement.

Anyone aged 16 years or older is eligible to join and lifetime memberships cost \$5.00. Assessed membership, as distinguished from lifetime, may be paid annually to

help cover programs and services not covered by Medicare. Members who pay the additional assessed membership fee benefit by receiving discounts on chargeable services and equipment rental. Most services are available with or without a membership.

Clinic C offers a comprehensive and impressive array of programs and services to its members and to the community at large. Community programs include community health workers, nutrition and dietetic counselling, advocacy, and health education and health promotion. Community Program staff also provide transportation to appointments at the health centre, hospital or referrals by wheelchair equipped van; liaison and support for aboriginal clients; counselling and support to abused women; dental treatment, education and prevention to school students; individual, family and group counselling; research and health promotion on family violence; workshops and classes; self-help support groups; health education materials and internet access; volunteer support; and, a drug addiction recovery program.

Physicians and support staff in family practice, internal medicine, general surgery, paediatrics and obstetrics and gynaecology provide a broad range of services and comprehensive care for patients. Nursing staff provide health assessment, diagnostic screening, health teaching, disease management, nursing care, referrals to other services, complementary therapies, visiting nurses, and palliative care. Laboratory staff provide laboratory tests, ECG heart testing, and ambulatory blood pressure monitoring. Diagnostic imaging staff provide X-ray and ultrasound procedures. Physiotherapy staff provide therapy treatments and run seniors' exercise groups.

5.4 Case Study Summary

Although the Community Clinics being studied are located in fairly similar urban settings, it is interesting to note that they are each able to address the specific and different health care challenges of the populations in their respective centre. All have a community development focus and make special efforts to work with marginalized populations. The Community Clinics take a health promotion and prevention approach to the provision of primary health care services. To a greater or lesser degree, they work to address not only immediate health care needs but also the determinants of health. All offer a wide range of services that are available in one place. The Community Clinics, also to a greater or lesser degree, have innovated with respect to developing new programs and services to meet the needs of their members and users. Key characteristics of the Clinics are given in Table 2 (see page 98).

Table 2 – Key Characteristics of the Community Clinics

Key Characteristics	Clinic A	Clinic B	Clinic C
Advocacy and Lobbying	Strongly emphasized	Less strongly emphasized	Not emphasized
Health promotion and prevention	√	√	√
Interdisciplinary teams	√	√	√
Targeted groups	√	√	√
Tailored services and programs	√	√	√
Doctors on salary or contract	√	√	√
Incorporation	Mutual Medical and Hospital Benefits Associations Act	The Co-operatives Act	The Co-operatives Act
Number of members	11,000	3,200	7,000
Number of users	14,000 more	14,689 on total membership list	16,000
Number of staff	125 full- and part-time	51	52

There are common elements among the three Community Clinics, such as the interdisciplinary and holistic approach taken to primary health care, yet there are significant differences. These differences became more visible in the data that was derived from the key informant interview transcripts that follows.

5.5 Findings from the Data

5.5.1 Endogenous Characteristics of the Co-operative Community Clinics

According to Stanbury (1993), the endogenous characteristics of interest group include organizational variables – structure, governance, and core activities (other than advocacy). These variables are characteristics that organizations can control and change over time. With respect to the Community Clinics, their endogenous characteristics include their autonomy, democratic governance, boards of directors, community-based nature, inter- or multidisciplinary approach, primary health care model, and member ownership. The Clinics' core activities have been described in the previous sections.

As a group, Clinic informants raised issues with respect to the Clinics' endogenous characteristics more frequently than other informant groups did, particularly those related to their autonomy, the co-operative model of primary health care delivery, governance and ownership. Clinic informants have had a longstanding concern about lack of recognition of the co-operative model of primary health care delivery. The potential loss of Clinic autonomy has been a concern of the boards and administrators of all three Clinics for some time. Officials in the Department of Health have tried at least twice to have the Clinics folded into their respective Health Regions to come under Health Region control (Transcript 1).

When these attempts were made, the Community Clinics fought back. Initially the Districts were not given responsibility for primary health care, but when the Regions were formed, this changed. In the mid- to late 1990s, there were cutbacks in funding for health care in response to a period of economic crisis. One Clinic's annual report from that period stated that:

The District Health Board and Saskatchewan Health have been so consumed by trying to cut cost in the institutional sector they have had little time for community based services like ours. We hope...that they will begin to appreciate and support our potential to foster good health.

The Province has told us they intend to eventually transfer funding responsibility to the District Health Boards. We are very concerned about the consequences to Associations of such a transfer. We are working to influence the Province and District Boards to protect that which we value and to work in partnership with us to support and expand our model (1993-94 Annual Report).

All three Clinics feared that if the Health Districts were given responsibility for the Clinics, they would:

...not necessarily support the maintenance of the clinics and there was the possibility that two things could have happened: one – that they could have cut back resources for our clinics and we wouldn't have been able to meet our clients' needs as well, or two – they could have taken us apart. They were centralizing all of their functions like physical therapy, lab services, occupational therapy (Transcript 42).

The politicians seemed supportive of the Clinics at that time and through the Saskatchewan Community Co-operative Health Federation, representatives of the Clinics were able to meet with Cabinet to plead their case. The decision to keep the Clinics autonomous was made twice at the Cabinet table. An informant notes that the government made a commitment to the Clinics that the Clinics would only become the responsibility of the Health Regions when the Regions had made arrangements for alternate payment methods with a majority of individual and group practices in the Regions (Transcript 21). Since progress in negotiating alternate payment mechanisms with the doctors has been slow, there is no perceived threat of the Regions gaining control over the Clinics for quite some time (Transcript 42).

On the other hand, officials of the Department of Health are regarded as anxious to control the Clinics: "The bureaucracy wants a system they can control. They can't

control the Clinics. They view them as problems. The Clinics don't fit into boxes" (Transcript 42). This informant's view is that the officials are very strong and have never supported the Clinics. Because there is no legislative framework to enable new Clinics, they do not get set up, and the politicians are cautious in how they support the Clinics and in what they say (Transcript 2).

Another Clinic informant notes that Department of Health officials view the co-operative Clinic model as a disadvantage because they cannot exercise as much control over the organization as they would like:

...well, as a co-operative of course we've got a disadvantage that we're not autonomous because we operate at the whims of the government. As you know, one of the co-operative principles is independence and autonomy and we're not able to do that... Well, we are but the government also has the right to withdraw our funding, in which case we'd be screwed...

We're independent in that we can choose to accept or to not accept government funding, but on the other hand it is so crucial to our survival that without it we'd be nothing more than a small lobby group of people, perhaps. Not able to provide any real services (Transcript 32).

When asked about the Clinics' role in the health care system in the province, Department of Health officials simply say that there are five in operation (Transcripts 15, 27). The implication seems to be that the department will deal with them because they exist but the officials consistently cite the Health Regions legislation (*The Regional Health Services Act*, Chapter R-8.2* of The Statutes of Saskatchewan, 2002 as amended by the Statutes of Saskatchewan, 2002, c.C-11.1; 2003, c.25; 2004, c.49; 2004, c.51; 2004, c.C-11.2; and 2005, c.M-36.1) as setting out the mandate they must implement. The Department of Health has itself been reorganized to reflect the structure of the health system; it is set up to deal with and support the Regions (Transcript 22). The addition of

a Primary Health Care Branch is relatively recent.

Department officials would rather not have to deal with the Clinics and there is no support for establishing new ones. Department of Health officials say that they have not been approached to establish any new co-operative Clinics and the existing Clinics are now referred to as “primary care sites” in the health care system, further reflecting the pull of integration (Transcripts 16, 28).

Another informant reiterates the concerns about accountability and measurement and evaluation of the Clinics, saying that Department of Health officials want proof that the Clinics provide efficient and effective service delivery (Transcript 41). Where fee-for-service practices allot seven minutes or so to each patient, the Clinics’ physicians spend more time with every person – something in the range of 21 minutes. The Clinics are seen as providing better care because the patient is able to access multiple services in one place and that different members of the Clinics’ interdisciplinary teams can access the patient’s records and discuss with each other what the patient’s care should be. The officials, however, regard the Clinic model as an expensive delivery mechanism for the other services, for instance, physiotherapy and counseling, which would not normally be associated with fee-for-service practice. There is considerable pressure on the Clinics by the Department of Health to quantify their efficiency and effectiveness (Transcript 41).

Clinic autonomy seems to be associated with the past more than with the future. One informant was careful to describe the Region’s current relationship with the Clinic in its area as resulting in large part from the Clinic’s history with the provincial government:

Yes, we have a relationship but to me we have to back up a little bit historically. I think the Community Clinics have been in operation for some time prior to all of this reform and the establishment of the Health Regions. As so it was basically, I’m assuming, I might be wrong, but the

[Case B] Clinic established itself as a co-operative and they did that in direct negotiations with Saskatchewan Health around funding... Basically they developed and continue to have their primary working relationship with the province when it comes to funding... and that is a historical fact. And then along came the districts, along came these bigger Regions and what Health has said to the Regions is, 'We are going to give you a basket of dollars.' And we have a working agreement with them and a legislative framework that we are responsible for delivering the comprehensive array of health care services. It is our job to integrate, plan and provide that kind of leadership. And so we've been mandated to do that and that's how we try to work (Transcript 11).

The historical relationship between one Clinic and the government places the Region itself between the Department of Health and the Clinic, making it difficult for the Region and this Clinic to establish a positive working relationship (Transcript 30). The Clinic essentially serves two masters – the Health Region and the Department of Health. Where before this Clinic could approach the Department of Health directly for funding, it is now told to deal with the Health Region to secure funds for programs and services apart from its core funding. The Clinic has to negotiate with the Region and meet the Region's priorities and strategies.

The same Region also has to deal with conflicting demands from a number of groups and the Clinic is but one of these. The Region places great emphasis on achieving a common strategy in keeping with its mandate:

So the Community Clinics basically have been more independent and autonomous and have done their own assessment and planning and they've come up with an agenda and they want us to buy it. And our strategy has been more one of, we need to develop a common strategy and agenda based on a whole host of competing interests. Partner with us and we'll come up with one that's common. I think what we sometimes have is a polite, friendly but bit of an arm wrestle around whose autonomy is whose – are we in the lead? [The Department of] Health has given us that mandate so therefore the Clinics should basically say, 'How do we respond to the needs of [community] and area and the Health Region – what is your agenda and how can we support that and how can we

influence that?' We probably prefer that kind of rapport. I think that we sometimes find that the Clinic says, 'Well, we're a board, we're autonomous, we've had this history' (Transcript 13).

Although there is perceived value in the multidisciplinary team approach and in having physicians on alternate payment methods, the autonomous governance of the Clinic is an issue for this Health Region (Transcript 13). At the time of the interview, the government's priority was to move fee-for-service physicians to alternate methods of remuneration, including salary and contract (Transcript 30). This policy position has influenced the Health Region's relationship with the Clinic in that the Region is spending less time working with the Clinic and more time in working with physicians on this matter. The province's efforts to develop a model contract with the Saskatchewan Medical Association have not yet been successful because the SMA is very resistant to the idea of alternate remuneration for its members:

It's a huge step but that's where the province wants us to invest, but SMA and the province are not on the same page with this. So SMA has basically told their physician members, 'Don't sign anything with the Region around the contract until we say it's okay.' Well, we've got some physician groups saying, 'Okay, no, we won't talk about it,' but others are still quite interested (Transcript 30).

The emphasis the Clinics place on autonomy appears to be countered by the government's emphasis on integration. The priorities of the government's health policy thus place the Health Regions and the Community Clinics into conflict with each other. The leadership of the Clinics has been accustomed to dealing directly with either the politicians or with Department of Health officials (Transcript 30). Now that the Regions have responsibility for primary health care, access to this venue for Clinic lobbying is being cut off.

A word that did not appear in the transcripts is innovation. Instead, it appeared in the form of a metaphor:

Someone gave me a model between a speedboat and an ocean liner, and maybe our Health Region is like the ocean liner and we can be a bit more like the speedboat, which can do things for the community, sort of experimental or leading edge things that others haven't thought of...it's one of those sorts of things where it seems to take a large bureaucracy a long time to be able to do the right thing where we can perhaps be a bit more nimble (Transcript 32).

It may be that the Clinics' endogenous characteristics have stimulated their record of innovation in primary health care. For instance, Clinic A developed a drug formulary later adopted by the province as a provincial drug plan, and employed the first medical social worker in a clinic setting. Another example is that one Clinic's nurses had to meet the needs of many clients that were previously met in the hospitals in response to the impact of the changes in the health care system. Activity increased in the areas of counseling, advice, health teaching and triaging of patients over the phone. Efforts were made to obtain funding for a nurse-run health phone line. The project was developed in conjunction with the Saskatchewan Registered Nurses Association. The Clinic approached the Health Region and the Department of Health to fund a service that would provide people with the option of calling an experienced registered nurse for advice and health education. This is normally provided during the day by the Clinic's nurses, but the project was intended to operate in the evenings and part of the weekend. The objective was to reduce the number of unnecessary visits to emergency rooms, reduce double doctoring, provide people with health education, and consequently empower people to take more responsibility for their own health. The Clinic was not successful in securing funding for a pilot project but, ultimately, the Department of Health established its own

“Telehealth” service for the entire province.

The analogy of speedboat versus ocean liner seems apt. This Clinic, as well as the others, has a structural advantage in that its size and closeness to its members allows it to try new things that are targeted for their specific needs. What will happen to this and the other Clinics’ records of innovation if the Health Regions that are their ocean liners absorb the speedboats into these large bureaucracies? It seems that the flexibility and nimbleness of the Clinic could very well be lost. This loss of the ability to innovate has larger implications in that new things tried at the individual Clinic level can be, and have been, adopted at provincial and national levels in the past.

The metaphor of “speed boat versus ocean liner” presents an important point of comparison between the Community Clinics and the Health Regions. It suggests that the Clinics are more able to innovate because they are smaller and more nimble, and have the flexibility that the Health Regions do not possess. However, the Clinics do not have the resources that the Health Regions possess, and Rogers (1995) notes that this is one reason why larger organizations can and do innovate. In his terms, the Clinics would be classified as entrepreneurial or “venturesome innovators”, while the Health Regions would be “traditional laggards” (Rogers 1995: 262-266).

There may be an additional reason for the Clinics’ record of innovation. Clinic staff do their work as members of interdisciplinary teams. The social dynamics of working this way may lead to innovation – people talk, think, experiment together, bringing the knowledge and experience of different health care professions to bear on the needs of Clinic members and users.

The endogenous characteristics of the Clinics are key factors in both Clinic autonomy and innovation. Clinic autonomy arises from the co-operative model itself and is a core feature of Clinic structure and governance. The core activities, in other words the services and programs they provide for their members and users, seem to have led to Clinic innovation.

5.5.2 Exogenous Variables Affecting the Community Clinics

The exogenous variables affecting the Community Clinics include variables over which they have no or limited control. Following Stanbury's framework, these variables would include the relationship among the members, the degree of government intervention in the field, the degree of dependency on government actions, the characteristics of the members, and public perceptions of the organization. This section focuses on the characteristics of and relationships among the members of the Community Clinics, the degree of government intervention in the field, and the public's perception of the community Clinics. The degree of dependency by the Community Clinics on government action is also discussed in other sections.

As may be expected, issues related to the Community Clinics' exogenous characteristics were raised most often by Clinic informants, followed closely by the political informants. The issue of the Community Clinics' close ties with the NDP arises, as does the differences among Community Clinic members with respect to age and understanding of the co-operative nature of the clinic model. The degree of government intervention and issues of power and control also emerge.

One informant thinks that health care co-operatives can play a central role in primary health care in the province, but has found that the past still influences how the Clinic is perceived today (Transcript 35). This informant thinks that the general public in that particular Clinic's surrounding community is not aware of what the Clinic does and that people are hesitant to come to the Clinic because of its historical association with the NDP. With respect to the impact of the past on the present, one informant indicated that:

...there are people that remember 1962 like it was yesterday and they haven't moved on. And you know while the formation of co-operative health centres in 1962 was very futuristic in many respects, I find from some aspects they haven't moved on from there...they maintain the status quo... (Transcript 8).

5.5.2.1 Public Perceptions and Beliefs

Some informants think that the Community Clinics were ahead of their time and that time has caught up to them. Are they frozen in time in some respects? One informant thinks there were more advantages to the co-operative Clinic model in the past than there are now (Transcript 35). Today, the public has access to more options in health care, for example, walk-in clinics that are open around the clock; it is hard for this informant's Clinic to compete with that.

One Clinic's identity is in part bound up with the perception that it was closely associated with the NDP (Transcripts 5, 37). This perception has been problematic for the Clinic. A Clinic representative who was a self-described "high profile person" in the CCF party and helped to establish this Clinic notes that:

Some of the physicians and one of the directors of the physicians was very concerned about the high involvement of the CCF because they wanted it to work as a medical clinic and if you come in later in the picture...where

you're saying that the government was a bit standoffish, you had to feel it was a rather mutual agreement for the clinic to take an arm's length position in order for them to be credible with all the opposition which was in the medical hierarchy (Transcript 38).

One Clinic representative did, however, see the need for this same Clinic to be a political organization in order to keep it running. This appears to mean political in terms of lobbying and advocacy. An example of this occurred when the Liberal government brought in deterrent fees:

In 1967 when the Liberal government was in office and we took a stand against the deterrent fees that were laid against people, we got something like 35,000 signatures from the clinic membership in order to defeat the Liberal government at that time. So you see we were never anti-NDP or anti-CCF. What we were was careful to try to encourage the medical staff on board. And that has been a struggle and I think is still a struggle from what I'm hearing about programs that are going on (Transcript 37).

The strength of the perceptions around this Clinic's association with the NDP also seems to have affected the possible establishment of new Community Clinics. When a suggestion to establish a Clinic in a rural location was made to a Department of Health official during the Liberals' tenure as government, the official's response was that as a bureaucrat, that would be a "kiss of death" (Transcript 6).

One Clinic informant, who was also a Clinic employee at one time, said that when Grant Devine was the Premier of the province, as leader of the Progressive Conservative (PC) Party, the PCs "were afraid to do anything with the Clinics, even though they would have liked to, because they thought the Clinics could mount some kind of mass protest if they did anything with them". The PCs were under the impression that the Community Clinics had a much larger membership base. This informant worked at the Clinic at that

time and “it was nice from that point of view that we had thrown fear in the government about touching us” (Transcript 37).

Informants from the same Clinic have also expressed the opinion that the co-operative movement itself did not regard the Community Clinics as “real” co-operatives. The Clinics had approached the Canadian Co-operative Association – Saskatchewan Region for support in advancing the Co-operative Clinic model in the province. What set them apart from “real” co-operatives seemed to be that the Clinics received almost all their funding from the government. Clinic representatives expressed disappointment that the co-operative movement did not give the Clinics the support they were asking for. There was also a question raised by the Canadian Co-operative Association – Saskatchewan Region around how the Clinics could operate as co-operatives under *The Mutual Medical and Hospital Benefits Association* legislation. It is not known if the co-operative movement in the province was concerned that the Community Clinics did not observe the co-operative principle of political neutrality. This may have been another reason that the co-operative movement in the province did not support them at that time (Transcript 37).

5.5.2.2 Member Characteristics

The influence of a generational difference is apparent in all of the Community Clinics; members probably had a stronger voice in the past:

Researcher: Do you think that is in part because of the aging of the membership overall?

Informant: Absolutely, absolutely. Founding members have history with this place. Many of them are active volunteers probably in their 70’s or 80’s...So they are passionate. So the founding members have a different

passion for this place than what new members do and our AGM's – we still hold them and it's harder and harder to get a quorum for us (Transcript 35).

In one Clinic, an informant indicated that the presence of older members who participated in establishing the Clinic is a limiting factor in that the members' connection to the past constrains them from making strategic decisions that would help the Clinic to respond to the current environment. The Medicare crisis remained very much in the present for these members. The differences in how Clinic founders and older members view the government's relationship with the Clinic and the current leaders' views demonstrate how the ideas of certain players affect the outcomes of Clinic decision-making and strategy. The founders of all three Clinics being studied view the establishment of the Clinics as a radical transformation of health care delivery in Saskatchewan. Current leaders view the health care system as having caught up to the Clinics; the Clinics are no longer radical as the basis of their operations become more mainstream – utilization of multidisciplinary teams, increased focus on promotion and prevention, and alternate physician remuneration schemes.

All three Clinics indicated that there were problems caused by the aging of their membership and the difficulty in attracting new members. The Clinics still have members who helped start the Clinics during the doctors' strike in 1962 and who continue to understand and value the importance of the co-operative model for the delivery of health care services. As the number of these members and supporters diminishes over time, there are not enough new members with the same understanding and appreciation of the co-operative model.

All three Clinics are also experiencing difficulty in attracting new members and new board members. The number of board members of one Clinic has been reduced from 12 to nine, as well as the number of people required for a quorum at annual general meetings. If an insufficient number of people attend the annual general meeting, it cannot proceed and another attempt must be made later, with no guarantee that a quorum would be achieved then. Planning for and holding these meetings consumes a lot of administrative time that could be used for other matters. In this instance, the democratic process can sometimes be a limitation (Transcript 8).

There is a need to find new members but people need to understand what the Clinics are. A former political representative commented on the generation gap in support for the Clinic model, saying that member and public support for the Clinics has waned over time (Transcript 42). This concern is not specific to the Clinics; it applies more generally to the co-operative movement in the province and elsewhere.

5.5.3 Interaction

The government seems to have established an environment in which the Community Clinics experience increasing constraints to their ability to make decisions. These constraints are being placed on the Clinics by the Health Regions. As the government's chosen policy instrument to achieve its goals in health care reform, the Health Regions have what the Clinics do not – a legislated mandate and the resources to carry out that mandate.

According to Stanbury (1993), the interaction component includes government's choice of governing instruments, controlling access to decisions, control over

information, and assisting countervailing forces. One of the government's instruments of choice is the legislation that established the Health Regions. This has impacted its interaction with the Clinics in different ways. The Health Region in which one Clinic is located favours integration. Much emphasis is placed on achieving a system that is "seamless" so that patients can flow more easily through it and there is better co-ordination and communication between the system's components (Transcript 3).

This same Health Region thinks that the Clinic within its boundaries has "enormous potential" for primary health care delivery but also that it needs to be part of an integrated system. The structure of the Health Regions is intended to "promote, enable, create integrated health systems". The need for accountability is also emphasized. The Clinic's status as a co-operative is seen as posing particular challenges because of its democratic nature and autonomy; because of this, "there's less control" of the Clinic (Transcript 40).

In spite of the challenges caused by the attitude of the Health Region toward this Clinic, the Clinic has worked with the Region in a number of ways. The Clinic has had a representative on the population health co-ordinating committee, the children and youth needs assessment group, the district's adult and seniors' needs assessment group. The Clinic asked the Health Region for citizen involvement in decision-making, support for those with difficulty accessing service, and greater emphasis on programs that address factors that affect health, such as employment, income and housing. The Clinic also had an agreement with the Health Region to provide physician services to a rural clinic in one small community and for a certain number of hours each week in another place. This Clinic believes that another agreement with the Health Region to jointly plan and deliver

primary health care represents recognition by the Health Region of the Clinic's strengths in the delivery of focused programs and services to meet its clients' particular needs (Transcript 42). However, given the goal of integration and the desire for control, it is unclear how this will play out in the future.

In contrast to the other Clinics, one Clinic and its Health Region seem to have gone beyond a somewhat distant but cordial relationship to a working relationship that encompasses a degree of co-ordination and planning. This seems to be largely due to the individuals involved. The parties involved appear to be focused on providing complementary programs and services, although there is still much work to be done to sort these out.

This does not mean that there are not any issues to deal with. The Health Region has concerns about overlap and duplication but recognizes that the Clinic is more efficient and effective in the delivery of some services, for instance, minor surgery (Transcript 34). There could be difficulties because of the different governance model if there were not a good relationship between the Clinic and the Health Region:

Well, if you didn't have a good relationship between the two – yes, it would be a huge disadvantage because they're two different funding sources, they're two different corporate structures. They're dealing with a board, similarly as are we; however, their board is an elected board by their membership using the co-operative way, whereas our board is government appointees which is a lot different and I mean you have the potential for a lot of vested interests, really (Transcript 9).

Competition for staff is an issue; the Clinic and the Region have different unions, different salary scales, different benefits, and so on. Clinic staff receive the same salary increases as the provincial health care unions do, but apparently do not receive the same benefits. As well, the management staff of the Clinic who are out-of-scope do not

receive these increases (Transcript 9). There is also some confusion about who is in charge of whom. But these problems seem to arise because of the government:

Informant: [Individual A] and me and our primary care consultant are sitting and essentially battling over, they fund [Individual A] say, and I'll use this for example, for clerical staff in our of our agencies where they've also provided us the physicians. So they are our employees but [Individual A] pays for that portion because of course part of the funding for physicians is the clerical support that goes there. So essentially the money is going from government to the co-operative health centre back to us who hire the employees. Whereas you know it's messy and...

Researcher: Administratively messy?

Informant: Yes. And you get in these battles over whose employees are whose and now as we move into primary care we just received word this week that we are probably going to get two nurse practitioners for that site so we're very happy about that. However, now we have the issue of who employs whom. The [clinic]'s wages are way lower. They're a different union, they're CUPE, so now whose bargaining work is it? They're going to be our people – they're going to be employed by the Region, yet they're going to be working in the co-operative health centre bargaining unit (Transcript 9).

The Department of Health thus seems to be complicating matters for both this Clinic and the Health Region. With respect to the possibility that the Clinic may be folded into the Region, the Health Region has told the Clinic that the Region does not want to take it, adding that the Clinic “runs 10 times more efficiently” than the Region ever could (Transcript 34). The Health Region also recognizes that the Clinic is better equipped to try to address the determinants of health. The Region does not do much community development work and this has not been regarded as belonging in the realm of health care.

However, the Clinic is not considered by some to have a “true” interdisciplinary team (Transcripts 9, 35). It is regarded as “very medically run still” and has not gone as

far as it needs to with prevention and promotion. The fact that this Clinic was founded by a physician seems to account somewhat for the dominance of the medical model. The Clinic's organizational structure is such that the doctors report directly to the board and the remaining staff report through the Clinic's executive director. This is understood to be a medical model of health care instead of a "real" primary health care team (Transcript 8). This contrasts with other views that the Clinic's founder initiated the concept of interdisciplinary teams and a holistic approach to patient care that included an emphasis on prevention (Transcript 19).

The degree of government intervention in the field is certainly related to the size of its expenditures on health care. There is no doubt that the restructuring of the institutional infrastructure made sense to the government. There was significant overlap and administrative duplication when each health care service operated on its own. Integration of ambulance, acute care, long-term care, home care and other services has helped to streamline and co-ordinate health care administration, planning and delivery (Lomas 2001; Lewis 1997).

Today's structure was not achieved without great controversy in the province. The closing of 52 rural hospitals was traumatic for the communities in which the hospitals were located and their surrounding areas. The loss of the hospitals represented not only the loss of health care services, it also represented the loss of the communities' identity, as well as the loss of the economic spinoffs generated by the hospitals in terms of employment for local residents and income for local suppliers of goods and services (McDermott et al. 1994; Liu et al. 2001). Having a hospital was a symbol of a community's identity and its ability to survive in rural Saskatchewan:

Residents of communities gain a measure of security, identity, and economic vitality from their local hospital. In Saskatchewan, small rural hospitals were viewed as part of community-based care, although serving limited medical needs, they served psychological needs. It is clear from the reactions of many of the residents that the community hospital contributed more than services but also to local identities (James 1999).

The restructuring also meant loss of control and ownership over the facilities, which were to be transformed into health centres supplying more every day services instead of acute care. This has had an impact on the Clinics, which, as co-operatives, are still community-based and member-owned. A Clinic representative noted that the provincial government has given the Health Regions more and more responsibility for service delivery and ownership of health care:

They want to deliver it directly, covering their views they can do that most efficiently, effectively and economically. You can see now that the Regions own acute cares and control them. They own almost all the long-term care facilities and control them and they own community health services and they own home care services and they don't have much motivation to turn those services over to private or semi-public organizations like not-for-profit co-operatives (Transcript 42).

Although there is potential for the establishment of semi-public entities to deliver primary care services, the Regions do not appear to be interested in doing this. Since the Regions have control over the allocation of resources, one informant does not see any potential for the development of new health care co-operatives:

At the end of the day though it is the Health Regions that make the decision about whether the funds can be allocated to that kind of entity and in almost all cases, if a health centre is to be started up they will just start it up themselves (Transcript 1).

The trend toward centralization of control has been noted by another informant, who said that there should have been a bigger role for the Clinics in health reform (Transcript 22). Health reform efforts in the 1990s were based on ideas about community

involvement and the Health Districts were set up for this. However, the Clinics were regarded as having a narrower focus than what was required for the Districts. The Clinics were focused on primary health care, while the Districts were to integrate and co-ordinate acute care, long-term care, home care, ambulance services and others. There was an opportunity then for the Districts to be set up as co-operatives but it happened so quickly that there was no time for a co-operative movement to develop to be able to handle district responsibilities. There was recognition that the development of co-operatives takes time but there was some urgency around establishing the Districts and making them operational (Transcript 21).

At the time the politicians were very aware of the co-operative model and the philosophy behind it; there was a big emphasis on community development and the need for community participation (Transcript 22). However, officials in the Department of Health wanted to make the districts larger and have less community control, so there was a tug-of-war between the politicians and the officials. When the Fyke Commission also recommended larger centres, the decision was made to maintain control at the centre of government (Transcript 21).

In addition, the government needed to manage the negative publicity around the closure of hospital beds so this was another reason to maintain control at the centre of government. This difference of opinion is why co-operatives did not get off the ground in health reform, although they did have a special place in the health districts initially. They could have developed 30 sites that were co-operative-driven. The government wanted more districts, not less, but the officials won in this regard (Transcript 22).

There is a commonly held belief among clinic supporters that the NDP government made a deal with the Saskatchewan Medical Association when the Saskatoon Agreement was signed such that no more co-operative Community Clinics would be established. This does not appear in the Saskatoon Agreement itself (quoted in Tollefson 1963) and thus far nothing in writing has been found that would confirm that such an agreement existed, yet Clinic representatives are adamant the deal was made (Transcripts 42, 5, 37).

Clinic informants also believe that the Saskatoon Agreement limited the Clinics to the role of landlords for the physicians who worked in the Clinics. The relevant clause in the agreement is cited in Rands (1994):

14. There may be places where few or no doctors have enrolled for direct payment by the Medical Care Insurance Commission, so that patients are denied the choice of such doctors. It is not for the Commission to appoint doctors in such places. The remedy is in the hands of the citizens themselves. They can establish premises and invite doctors who wish to enroll for direct payment to rent such premises and set up practice in them...The interest of such enrolled doctors must be safeguarded from improper citizen pressure. The role of the citizen group in the provision of insured services must be limited to that of landlord (Rands 1994: 116).

While the Saskatoon Agreement had the effect of formally authorizing Community Clinics (Rands 1994: 65), Clinic founders believed that it also severely limited their role with respect to directing how the Clinics would be run. The medical profession's concern was that laypersons would be able to "interfere" with the actual practice of medicine. This was not the Clinics' intent; rather, they wanted to establish a member-controlled organizational structure in which medical services would be provided according to the needs of the membership.

The Clinics are thought to have misinterpreted the intent of clause 14:

I think it's a wrong interpretation if it means that the Clinics could not go out and proselytize among the populous to join the Clinic. I think it was not intended, and I don't think did mean that. They did mean that they were not to direct the doctors on how to practice medicine and that the doctors were not employees in any professional sense of the Clinic, it was intended to mean that (Transcript 24).

The view that the government did not make an agreement with the medical profession regarding the further establishment of clinics is also held by another informant, who said that there was never any evidence of that during Premier Romanow's tenure in government (Transcript 25). In any case, whatever may have happened is over forty years in the past; should it really be a factor today (Transcript 18)? Nonetheless, the Clinics' supporters have long held this belief, a belief exacerbated by the fact that the Saskatoon Agreement did not include any other means of physician remuneration than fee-for-service. This clause seems to have had the effect that the Clinics' first doctors subsidized the Clinics' operations through their billings to the government on a fee-for-service basis (Reid 1988). It was not until 1994 that the department agreed to fund the Clinics directly on a global basis, which was still primarily based on fee-for-service remuneration.

When asked about the effect that the Saskatoon Agreement had on the Clinics, one government informant said:

There is no doubt that the Saskatoon Agreement was a compromise. It's very easy now to say that. It's always easy to say after a compromise is made which people deemed to be necessary to bring about a resolution of a dispute that the concession should not have been made with no corresponding elucidation of how the resolution to the problem could have been brought about without the particular concessions. The Saskatoon Agreement was almost a complete victory for the government, in the sense that we established the fact that there would be a single payer system (Transcript 19).

The Clinics have been credited with helping to bring the doctors' strike to a halt but Clinic representatives believe that the government of the day did not treat them fairly with respect to the Saskatoon Agreement. However, one informant noted that there is a mistaken notion that the government was completely in charge of the events that unfolded; it did have to make some concessions, one of which was a change in the legislation to remove the right of the government to make any regulations that might be perceived by the medical profession to interfere with their practice of clinical medicine. The government also needed to show that the Clinics would similarly not be able to interfere (Transcript 19).

Despite a belief, which has reached near mythic proportions in clinic lore, that they were limited by the Saskatoon Agreement to being landlords, some clinic supporters also believe that the elected members of the NDP government remain supporters and friends of the Clinic (Transcripts 42, 2, 11). When the NDP returned to power in 1991, the Clinics supported the government's health reform initiatives, while at the same time lobbying the government to gain a more secure place for the Clinics in the health care system in the province.

Another part of clinic lore is that when the NDP returned to power in 1991, officials at the Ministry of Health were told to "leave the Clinics alone". This comment was taken by Clinic supporters to mean that the Clinics were not to be negatively affected by the changes occurring in the institutional infrastructure and that they would continue to be supported and perhaps had an opportunity to have this support increased (Transcript 7). Ministry of Health officials may have interpreted this differently, however. The Clinics were left alone in the sense that the officials have never done a formal analysis of

which the Clinics' place in the health care system should be (Transcript 23). In not doing so, they have missed an opportunity to learn from the Clinics' long experience with alternate forms of physician remuneration and interdisciplinary service delivery. As another informant puts it:

Now back in 1991, 1992 there is no big mystery. We didn't sit around the Cabinet table and try to figure out how to exclude or how not to bring in the Community Clinics. There was no big mystery to that question. If you put yourselves, by imagination, in our shoes we had a real battle going on for the entire system and a fiscal situation as well which is about to bring the whole house down. So that was where our attention was focused. So one could argue at worst, well, this is benign neglect or willful neglect and we didn't get our proper place but I view it as a different answer. We had to deal with the hospitals and we had to restructure those if we had any hope in controlling costs and bringing transparency to life. There is not that much deliberate policy of care in government, as you in government would know, as a lot of people think there is (Transcript 28).

At the time, officials of the Ministry of Health and elected members of the government concentrated on restructuring the institutional infrastructure and did not address how to reform the delivery of primary health care. The challenges faced by department officials are acknowledged:

I think that the challenge again for them is there are lots of interest groups out there demanding, placing demands on them, including the SMA and the CMA⁴. The bureaucracy has been through many, many battles with these folks and they know [the] political consequences of that (Transcript 28).

This would at least in part account for the officials' inattention to the potential contributions of the Clinic model. Related to that challenge was the one caused by the necessity to make funding cutbacks in a period of economic recession. Competition by interest groups was fierce and the Clinics had to be seen to suffer constraints along with

⁴ SMA is the Saskatchewan Medical Association; CMA is the Canadian Medical Association.

all the other groups. With respect to the Clinics' funding needs post-Medicare crisis, an informant says that:

The Clinics had a slightly better case in the sense that this was a new endeavour and it was something more, it was something more than simply delivering medical services. It was to be, in essence, a new way of delivering medical services and to put it more broadly a new way to deliver health services and one that involved a melding of preventive health, social supports with the simple delivery of clinical medicine. It was more than that and the add-ons were not being sufficiently funded by the government. I think there's a bit of a case to that because I think the government was trying to maintain some sort of relations with the medical profession which were exceedingly rocky after the strike (Transcript 24).

5.54 Endogenous Characteristics of Government

Following Stanbury's (1993) framework, the endogenous characteristics of this component are matters that are in the hands of government, including the choice of governing instrument, control over information, control over access to participation in the policy-making process and its internal functioning, the scale or intensity of use of the governing instrument, the timing of government actions, and the design of legislation.

Although Stanbury (1993) addresses the internal cohesion of the other party to the relationship – the interest group or organization – he does not do so with the government. It was necessary to add this because there are significant differences among the politicians and department officials. The Health Regions are the creations of the government, including both politicians and department officials, and have a legislated mandate.

5.5.4.1 Internal Cohesion

The Clinics have received mixed messages from the politicians and Department of Health officials. The relationship of one Clinic with its designated consultant in the Primary Health Care Branch of the department is described in positive terms, while at the same time Clinic informants say that the Clinics are viewed as an anomaly, as different, as not fitting the model, as a nuisance, and as a “pain in the butt” by the same department (Transcripts 31, 11). Access to the Minister of Health has at times been limited, while [community] MLAs have attended Clinic events and voiced their support.

The ambiguity around the relationship of the Clinics with the politicians versus some government officials gives rise to the question: Why does the government continue to fund the Clinics? Two informants were not sure, but speculated that:

...maybe they keep funding us only because the political fallout from not funding us would be worse (Transcript 32).

...we can't be cut loose because we're part of the history of Medicare (Transcript 12).

A different informant said that the government may maintain the Clinics as a symbol to the medical profession that an alternative to fee-for-service practice exists:

Informant: The public health care model in Saskatchewan is perhaps as good as anywhere and so the gap between, what it is and what it should be isn't that huge. And under those circumstances, the co-operatives don't thrive.

Researcher: True, if you look at them developing out of a need where the private sector or the public sector hasn't been willing or able to provide goods and services that are needed.

Informant: Yes. So perhaps our role is more to monitor what is and try and tweak rather than fill a big gap (Transcript 32).

This informant unknowingly echoed Torgerson et al. (1998) in identifying a public policy role for the Community Clinics similar to that played by agricultural co-operatives in the United States, that being a sort of competitive yardstick to the medical profession in the province. Another informant also pointed to the policy role that the Saskatchewan Wheat Pool played when it was still a co-operative, but noted that the retail co-operative system could perform a similar role for consumers but does not. The informant sees a parallel with the retail co-operative stores, especially in the rural areas: "...the co-op store was there because without it there would have been a huge gap between what this kind of situation would have been and what was required" (Transcript 1).

In urban centres there is not the same kind of gap in services so that if the co-operative retail stores did not exist, it would not make that much difference. As to the advantages of belonging to a Community Clinic, "Well, they're not as obvious as they were in the past because I think the public model has kind of caught up to us now..." (Transcript 32). The gap in services seems to have also closed in terms of the Community Clinics, so perhaps they no longer make that much difference. This is perhaps one reason why potential new and younger members no longer see the advantage of belonging to a co-operative Community Clinic.

Another informant notes that the relationship between the politicians and department officials is "symbiotic" (Transcript 2). The politicians give direction to department officials about what their priorities are, and the officials give their advice to the politicians about best options to take action. The officials say that the government chose the District (now Region) model. It seems that even though the politicians appeared to support the Community Clinics, the officials were not directed to give them

more priority and attention throughout health reform efforts. Some politicians interviewed for this research appear to blame the officials while also indicating that there was a lack of political will to expand the Clinic model.

5.5.5 Exogenous Variables Affecting Government

According to Stanbury (1993), the exogenous variables affecting government include the existing means of government intervention, the size of the government's majority in the legislature, the regional distribution of seats, and the constitutional allocation of powers.

The provincial government has at its disposal a full array of instruments by which to intervene in a policy domain, including that of health care policy. As discussed in Chapter Three, this can include legislation, regulation, administrative practices, budget allocations, policy and program statements and procedures, speeches, briefing notes, and cabinet submissions. It can also include doing nothing.

The size of the government's majority in the legislature can influence the choice of governing instruments, timing of government action, and strategies to retain a majority. The regional distribution of seats, e.g. urban versus rural, or north versus south, can also influence policy decision-making. In the case of the Community Clinics, neither the size of the majority nor the regional distribution of seats appears to have had an effect. Timing in terms of where the governing party is in their term may have influenced the NDP's decision to tackle reform of the institutional landscape of health care in the province early in their first term after resuming power in 1991.

The constitutional allocation of powers, i.e. the division of powers between the federal government and the provincial governments, does not appear to have had any bearing on public policy toward the Clinics. Health care is primarily a provincial matter, although the federal government plays a strong role in funding and in ensuring that the provinces follow the principles of Medicare⁵.

5.5.6 Influence Processes Used by the Community Clinics

Influence processes include lobbying and advocacy, use of the media to influence public opinion, participation in the political process and stimulating the grass roots. One Clinic is arguably more politically active than the rest of the Clinics in Saskatchewan. Clinic A has a standing Political and Social Action Committee, the purpose of which is to monitor political and social trends and issues that may affect the Clinic. The committee makes recommendations to the Board of Directors with respect to actions that could be taken to address political and social trends and issues.

The Political and Social Action Committee has undertaken numerous lobbying and advocacy activities over the years. When members of the District Health Boards were elected, the committee attempted to influence the elections in keeping with the values of Clinic A. In 1994/95, Clinic A worked with the Saskatchewan Health Coalition and held a news conference in which four founding activists in Saskatchewan, the first province to establish Medicare in Canada, challenged then Prime Minister Jean Chretien's policies and statements with respect to Canadian Medicare (Annual Report

⁵ The federal government provides funding through cash and tax transfers to the provinces and a territory to help pay for health care services, but the actual delivery of services is a provincial/territorial responsibility. If provinces or territories do not adhere to the principles of Medicare, the federal government can withhold funds.

1994-95). The panel included former Premier Allan Blakeney, Dr. Frank Coburn, Dr. Margaret Mahood, and “Smokey” Robson.

Political action also included unveiling a memorial to the introduction of Medicare in Saskatchewan, and leading efforts by the provincial Federation and the National Alliance of Community Health Centres to ensure that health programs would be protected in the North American Free Trade Agreement (Annual Report 1997-98). In 1997-98, the Clinic co-sponsored a national conference on protecting and strengthening the national Medicare system. The conference, entitled “Thirty Years of National Medicare: Forward or Backward Since 1967?” attracted 300 participants.

In 1998-99, Clinic A worked to try to ensure that legislation on physician incorporation would not compromise the principles of Medicare; lobbied against the Multilateral Agreement on Investment (MAI)⁶; advocated for restricted tobacco marketing and preventing the use of tobacco; and, advocated for a national pharmacare program and against the high cost of drugs (Annual Report 1998-99).

In 2000-01, the Saskatchewan Community Co-operative Health Federation made a presentation to the Romanow Commission advocating for further development of the community health centre approach to primary health care (Annual Report 2000-01).

Clinic A also provided a workshop to the Saskatchewan Association of Health Organizations at the association’s annual conference to inform health district representatives about the benefits of the co-operative Clinic model. Representatives of

⁶ “The Multilateral Agreement on Investment (MAI) was negotiated between members of the Organisation for Economic Co-operation and Development (OECD) between 1995 and 1998. Its purpose was to develop multilateral rules that would ensure international investment was governed in a more systematic and uniform way between states. When it was leaked to the public it met with intense skepticism, as the rules in the agreement looked to undermine the sovereign power of the Nations that were in negotiation” (Wikipedia). The agreement was not finalized. Clinic members were concerned that the MAI would threaten Canada’s public health care by setting the stage for a two-tiered system.

Clinic A worked with the Saskatchewan Community Health Co-operative Federation, the Saskatchewan Health Coalition, the Canadian Association of Community Health Centre Associations and the Canadian Co-operative Association to present briefs and lobby the provincial government, the Romanow Commission, the Senate Committee examining health care, and the general public for continued support and enhancement of a publicly-funded health care system, and for further development of Community Clinics. The Clinic also sponsored a public celebration of Medicare at the location where the original Medicare agreement was signed forty years ago.

Clinic A celebrated its 40th anniversary in 2002-03. It focused on responding to the report of the Romanow Commission, with some board and staff members participating in media events on the report. Clinic A supported the activities of the Saskatchewan Health Coalition and the board was represented in a national lobby of Members of Parliament in Ottawa organized by the Canadian Health Coalition in support of the Romanow recommendations. Because of Clinic A, the Federation hosted a national conference of the Canadian Alliance of Community Health Centre Associations in Saskatoon (Annual Report 2002-03).

Clinic A has provided a voice for its own members and clients specifically, for the co-operative model of delivery of primary health care services, and has participated in advocacy and lobbying efforts in defense of publicly-funded health care generally (Transcript 1). As Church et al. (2006) note, community health centres are well-equipped – perhaps uniquely equipped – to:

...provide a wide range of opportunities for citizen participation not found in most parts of the health care system. Opportunities range from consultation to direct decision making. Citizens are able to participate as service recipients, volunteers, and policy makers. CHCs are particularly

adept at facilitating participation because of their unique mix of organizational culture, leadership, structures, and processes. In essence, CHCs foster environments in which community members and staff feel empowered to participate in decision making. Opportunities for citizen participation range from mobilization activities such as letter writing, petitions, and public meeting attendance to more formal roles such as providing volunteer program support, planning and delivering programs, and participating in the governance of the CHC through the board of governance and its various sub-committees (Church et al. 2006).

It is important to note, however, that there are significant differences in how the three Clinics viewed their role in lobbying and political advocacy. Clinic A discussed above is very active in advocacy and lobbying, not only for its own resource needs but also for Medicare in general and in addressing the determinants of health. Clinic B is somewhat less active but does view its role in advocacy and lobbying as legitimate. Clinic C does not view political lobbying and advocacy as legitimate; the view of one informant is that the board is just interested in providing services to Clinic C members: “They’re interested in this health centre and making it operate as a health centre, focusing on primary health care and moving forward in care” (Transcript 8). Clinic C’s board has talked about what the advantage of being a co-operative is. They consider that being a member confers some monetary advantage with respect to non-insured services, as well as the opportunity to be a board member and have some decision-making ability, although the board “speaks with one voice”. In spite of this, it is clear that the agenda for Clinic C is largely set by Saskatchewan Health, through Clinic C’s service agreement with the department, and by the Health Region. While Clinic C and its Health Region try to work together in a complementary fashion, it is recognized that there is a loss of autonomy (Transcript 35).

5.5.7 Influence Processes Used by the Medical Profession

Text in the transcripts showed that the medical establishment's influence continues to be very strong. The SMA is a key player in the health care policy domain in Saskatchewan, as illustrated by Figure (see page 81). Its influence and power are really exogenous forces affecting the provincial government and the Community Clinics. Stanbury's (1993) framework does not appear to recognize the power that third parties may have in the relationship between an interest group and the government. The influence processes used by the medical profession are added here to address this gap.

The push toward privatization of medical care is a force to be reckoned with by both politicians and Department of Health officials, at provincial and national levels. One informant sees a strong push to go back to fee-for-service remuneration at both the Canadian Medical Association and the Saskatchewan Medical Association levels, and points to the role that medical education plays in perpetuating the medical model of health care delivery in which the physician is essentially a business person (Transcript 18).⁷ Little attention is given to community-based models. Even though some newly graduated doctors may see some value in salaried practice, the dominant paradigm still seems to prevail (Transcript 25). The SMA is very resistant to alternative methods of remuneration and the Department of Health is finding progress in achieving agreement on a model contract to be very slow (Transcripts 1, 14).

⁷ In June 2005, the Supreme Court of Canada decided that Quebec's prohibition on using private insurance to pay for medical procedures that are publicly available violated the right of patients to obtain private care when there was a long waiting list for the procedures they required. This decision is known as the Chaoulli decision after the Quebec doctor who challenged this ban. In August 2005, the Supreme Court decided to suspend its judgment for a year. Both the Quebec and federal governments asked for a delay in its implementation. The delay was granted but expired on June 8, 2006.

Although there is evidence that some doctors support publicly-funded health care in Canada, the medical profession is still in favour of at least keeping private insurance as an alternative to Medicare. At the 2006 annual conference of the Canadian Medical Association in Charlottetown, doctors voted in favour of “patients having the option of purchasing private health insurance as a possible solution to the problem of not getting timely medically necessary treatment in the public system” (Greenaway, August 24, 2006). The president of the association believes “there is a place for the private sector and for public and private partnerships” (Greenaway, August 23, 2006). The Canadian Doctors for Medicare media release for August 23, 2006 reported that:

Delegates at the Association meeting appeared to be taking views that contradicted each other in the extreme over the last several days. They repeatedly spoke of a commitment to the public system and passed motions they said were intended to strengthen and protect it but they also passed motions that would undermine and erode it. This includes a motion for physicians to be able to practice in both the publicly and privately funded systems, yet the current prohibition on this practice in Canada and many OECD countries forms the foundation of Canada’s publicly funded healthcare system (Canadian Doctors for Medicare. News Release).

The debate about private insurance versus a publicly-funded system is ongoing within the medical profession itself. On August 10, 2006, the government reached a three-year tentative agreement with SMA on a new fee-for-service contract (Government of Saskatchewan News Release, August 10 2006); the previous agreement expired on March 31, 2006. SMA members had asked the SMA Board to “re-activate the Political Action Committee to support the bargaining process” (Saskatchewan Medical Association, SMA News, July 2006). It is not known if this committee played any part in reaching an agreement. However, a new fee-for-service agreement would seem to indicate that the SMA is not yet willing to participate in alternate methods of payment.

A 2.8% increase in the fee schedule is being provided to physicians for each year of the three-year contract. Other incentives are provided in the form of additional funding for recruitment, retention and improved patient care.

While the Clinics were hopeful of recognition and an increased role in the reformed health care system, one Clinic informant feels that the Clinics actually stopped lobbying government on the assumption that they would be involved and that the government was their friend:

What happened is that the Clinics stopped a) fighting, but b) even messaging their story to the government and so when I look now at that transition from '99 to '01 to today, the Clinics were really flatlining in terms of their relationship with government. They weren't doing anything. And government was becoming much more distant. The messages of bureaucrats get every day up to the minister, you know, and I think that the Clinics were losing – they weren't messaging appropriately, they weren't messaging to the minister. He's a good friend of ours. Why would we have to tell him what the story is? (Transcript 41).

The Clinics came into very difficult times, and staff and programs at one Clinic had to be cut in during this period. The politicians wondered why they had not heard about the Clinics' funding problems before this came to pass (Transcript 2). The messages the Clinics were receiving from the elected members of government were contradictory:

The government claims it wants to see development and delivery of improved health care services like ours, yet they continue to give us lower increases in funding than those they give to district health boards. Moreover, their increases in funding to us are much less than our inflationary cost increases. We will continue our struggle to get the funding we need....

The Clinics seem to have used all of the methods at their disposal, with the exception of legal action, to influence the government. On the whole, their

success in doing so seems to have been limited. They continue to receive global funding from the government, but have not gained the recognition or additional resources they would like to have.

5.9 Summary

This chapter has presented information about the Community Clinics and findings from the key informant interviews. The descriptions show that the Community Clinics as social economy organizations are able to serve under- and un-served groups within the populations in their respective locations, and that they are able to tailor their programs and services according to the needs of marginalized populations. They are also able to develop innovative solutions to the challenges of serving these groups.

In summary, analysis of the data from the interview transcripts revealed that the Community Clinics fear that they will lose their autonomy and be subsumed by their respective Health Regions. Generational differences among their members are influencing their operations. The Community Clinics were perceived to be closely linked to the New Democratic Party. One Community Clinic has made considerable efforts to influence government policy-making. The data from the transcripts has also shown that influence of the medical profession in Saskatchewan is very strong. Misunderstandings about the intent and effect of the Saskatoon Agreement still influence the relationship between the Community Clinics and the government. There are differences between politicians and government officials with respect to how they view the Community Clinics.

It is clear from the findings that the relationship between the Community Clinics and the government, as mediated by the medical establishment, is complex and difficult to unravel. In the health care policy domain in Saskatchewan, the Community Clinics are challenged significantly by both internal and external factors. With the findings from the data, the following chapter examines the propositions arising from the literature on government-co-operative relations and the policy-making process and compares them to the experiences of the Community Clinics.

CHAPTER SIX: ASSESSING THE RESEARCH PROPOSITIONS

6.0 Introduction

The purpose of this chapter is to provide an analysis of the data obtained from the key informant interviews. The findings from the data are juxtaposed with the propositions set out in Chapters Two and Three to compare the experience of the Community Clinics with what was anticipated from the literature. The discussion that follows is organized around the propositions that were identified in Chapters Two and Three:

Proposition One:

The views of the government and those in the social economy can differ and conflict. While co-operative founders believe that the co-operative model of social economy organization allows their members to achieve control over the delivery of the goods and services they need, with the underlying ideology promoting a vision of a better society, government believes that co-operatives serve a public policy role by acting as a check and balance and serving as a competitive yardstick to the private sector.

Proposition Two:

Co-operatives can be expected to have little influence on government policy, except where their ability to act as a check and balance or competitive yardstick may address government priorities.

Proposition Three:

Achieving major changes in government policy towards co-operatives will be difficult, unless co-operatives have some resources to offer to government. The more valuable the resources that co-operatives can offer to government, the more power co-operatives will hold in the relationship.

Proposition Four:

Co-operatives will expect equitable relationships with government and the co-construction of public policy as it affects them, but will not be successful. The underlying ideas and ideologies of the government and other key actors in a policy field will often prevent this.

6.1 The Role of the Community Clinics in Public Policy in Saskatchewan

6.1.1 Proposition One

The views of the government and those in the social economy can differ and conflict. While co-operative founders believe that the co-operative model of social economy organization allows their members to achieve control over the delivery of the goods and services they need, with the underlying ideology promoting a vision of a better society, government believes that co-operatives serve a public policy role by acting as a check and balance and serving as a competitive yardstick to the private sector.

The data generally support the first proposition in that the views of the Community Clinics' founders do differ from and conflict with those of the government. These competing visions have led to disappointing differences between the expectations of the Clinics and the treatment they have received. There are also important differences in perspective among current Clinic informants and Clinic founders, and there is no clear indication that the government believes that the Community Clinics play a significant public policy role at this time, or what that role might be. Government appears to have been concerned about the vision of Clinic founders. As discussed later in this chapter, at several points in the Clinics' history, governments backed away from changes that they perceived would result in significant political opposition; they were apprehensive about the potential for transformative change that the co-operative Community Clinic model represented.

An important indicator of the differing views held by Clinic founders and the government concerns the Saskatoon Agreement. The Clinic informants interviewed for this study believe that the provincial government made a deal with the medical profession not to support the establishment of any more co-operative Community Clinics and that the Clinics were limited to being landlords for their doctors in the Clinics' early days

(Transcript 1). Although one of the political informants interviewed for this research said that that was not the intended effect of the agreement and another maintained that there has never been any evidence that such an agreement existed (Transcripts 18, 24), some Clinic leaders and members interviewed for this study believe that their difficulties in securing government support and in expanding the co-operative model are proof. Clinic advocates' views on the Saskatoon Agreement appears to have sustained political action by the Clinics and their Federation for over forty years.

The Saskatoon Agreement was the policy instrument utilized by the government to resolve the doctors' strike. In Hall's (1993) terms, it can be regarded as a third order policy change – one that achieved the overall goal of establishing publicly-funded and administered medical care, a major shift in public policy. But it also entrenched the paradigm of fee-for-service remuneration for doctors and marginalized the Community Clinics, however much the latter may not have been the intended outcome. Fee-for-service has remained the dominant paradigm since.

As discussed in Chapter Two, the relationship between the government and the established co-operatives was not close during the second phase of co-operative-government relations from 1944 to 1982 (Fairbairn 2000). Nor has it been since then, as subsequent relations have shown. Although the co-operative movement has believed that its goals were congruent with those of the government, this has not translated into substantive government support. What results is not quite what Doern and Phidd (1992) call "policy without resources" but, in the case of the Community Clinics, the resources provided are the minimum required to maintain them. As stated by a political informant, there is no political will to do anything more for the Community Clinics (Transcript 22).

Evidence from the key informant interviews with Clinic informants and former politicians demonstrates that the Saskatoon Agreement has had a strong and lingering effect on the relationship between the Community Clinics and the government (Transcripts 1, 24, 32). These interviews took place well over forty years after the Saskatoon Agreement was signed, yet the individuals, some of whom were directly involved in the Clinics or the government at the time, had very clear memories of the events that unfolded together with very definite opinions about the impact of the Saskatoon Agreement on the Clinics.

Differences in viewpoint among Clinic informants who were not founders add to the complexity of the relationship between the Clinics and the government. Two Clinic informants who were not Clinic founders appeared to believe quite strongly in the co-operative model for delivering primary health care services; one of these two goes so far as to say that the model is “near perfect” and could and should be utilized to organize primary health care delivery across Canada:

Clinic Informant: ... I would like to see the model spread across the whole blasted city, region, province and country because we Canadians deserve better health care than we're getting. I think the professionals in the system are excellent but it really does come down to how can a physician diagnose somebody with spending seven minutes with them, that is typically what it is set to, seven minutes, a file that they haven't read or won't read because they're too busy to read it and with someone they don't or may not know well (Transcript 41).

In contrast, a current informant at a different Clinic does not appear to share the same vision and was hard pressed to identify any advantages of being a member of a co-operative Community Clinic:

Clinic Informant: Our board has talked about this as well and [another Clinic informant] will probably talk about this. I mean the board has talked about what really is the advantage. There's a decrease in some of

the non-insured services, so there's some monetary advantage. I mean the ability to be a board member and have some decision-making ability, I guess, though the board speaks with one voice... And I think that in the past the members probably had a stronger voice than what they do now (Transcript 35).

The differences among current Clinic informants and Clinic founders include the generational gap, conflicting views on how successful the Clinics are in achieving a holistic, interdisciplinary health promotion and prevention approach, and conflicting views about the appropriateness of advocacy and lobbying activity. These differences within and among the Clinics seem to show that in spite of some important commonalities, they should not be conceptualized as an uncomplicated, homogenous group of organizations.

Generational differences among clinic members and related ideological perspectives regarding the role of the Clinics in influencing health policy and health care delivery have emerged. These differences could result in loss of control and autonomy if the number of members continues to decrease. Older members who helped found the Clinics are steeped in the history of the Community Clinics and the co-operative principles by which they operate:

Clinic Informant: ...there are people that remember 1962 like it was yesterday and they haven't moved on. And you know while the formation of co-operative health centers in 1962 was very futuristic in many respects, I find from some aspects they haven't moved on from there...they maintain the status quo...(Transcript 8).

Clinic Informant: And then the last thing is the boards themselves were getting older. I mean I came onto the clinic board and I look at some of the other boards -- these folks were -- they knew Tommy Douglas. God! They must have babysat his kids! And so you get this group of people who are tired. They had forgotten how to fight the good fight or maybe they fought the good fight and now they're cruising to retirement and they like their board positions (Transcript 41).

Many younger members and users of the Community Clinics appear to have less understanding and appreciation of the Medicare crisis and co-operative philosophy. This is forcing the Clinics to change their bylaws, for instance, to reduce the number of board members or the number of members required for a quorum, because they are unable to interest the younger clients and users in running for board positions: “So the founding members have a different passion for this place than what new members do and our AGM’s – we still hold them and it’s harder and harder to get a quorum for us” (Transcript 35). A former political representative also noted that the generation gap is a factor decreasing public and member support for the Clinic model (Transcript 42). The underlying ideology of the Community Clinics is not as strong as it once was:

Political Informant: There was high motivation to establish the community clinics and with that a huge amount of spirit and vigor and innovation and an appeal to idealism. Once that diminishes, as it invariably does in any enterprise and a clinic is like any other institution, it just seems to become settled in its practices, then the degree of public membership commitment also tends to level off and not have the same kind of innovative approach or determined approach for innovation which is really required. A determination that just doesn't seem to exist the same extent that it did in the early days (Transcript 25).

The first proposition encompasses the notion that the co-operative model has provided Clinic founders with a vision of a better health care system, resulting from direct political action. While this may have been evident at the beginning of the Community Clinics, findings from the case study show that this is not universally true in more recent times. As noted previously, one Clinic is very active in its lobbying and advocacy efforts, one does undertake some activity but not to the same degree as the first, and one does little in the way of political action. Although they face some common threats, each has adopted a strategy for political action in response to the threats they

perceive in their own individual environments. For instance, Clinic A has lobbied for improved pedestrian crossings because of the large number of members who are elderly; Clinic B has lobbied for increased support for individuals suffering from Fetal Alcohol Spectrum Disorder. Clinic C, on the other hand, does not appear to actively lobby the provincial government; its strategy seems to focus on maintaining a positive working relationship with its local Health Region. The Federation lobbies on behalf of all of the Community Clinics but it is, in fact, most closely linked to the most politically active Community Clinic, which still strives to achieve a better health care system for all Canadian, not just its members.

The Clinic model has also provided members with a means of measuring the performance of private medical practices. One Clinic informant provided this example:

Clinic Informant: That grandma, who has become my example, sees her physician and her physician says "Grandma, you need to go down and get x-rays done, you need to get this blood test done". It's done instantaneously, there's no delay. Not necessarily grandma, but what about John the worker? There's no sort of real quantifiable loss in time, or productivity. He doesn't sit in the waiting room at the Wall Street X-ray clinic, ultrasound clinic and then he doesn't go to the blood clinic on 8th Street. Each of these is a substantial cost to the system due to the loss of productivity and redundancies in staff. So that is why the clinic model is even better because not only does it take that 20 minutes with the patient but then it puts the patient into a integrated service delivery model where grandma or John goes downstairs and they get their x-ray done and they get their blood test done, more importantly their blood test because we have an on-site lab, and in the course of that they have a conversation and John explains why he's there and the practitioner's got the sheet. Then he basically takes a look at the results on an instantaneous basis depending on how the physician has characterized the needs, and says you need to go back upstairs immediately. Let me phone the physician and get you back in now. I can't think of a better circle of care than that (Transcript 41).

This would seem to support the proposition that the Clinics serve a check-and-balance or competitive yardstick role, yet it is not clear that the government

conceptualises them in this way. The co-operative model presents an alternative model of efficiency and integration, but such gains are not measured in health care restructuring. Instead of articulating a policy on the Community Clinics that would offer some insight into what the provincial government views as the Clinics' role, officials of the Department of Health simply say that they exist (Transcript 15, 27). The implication seems to be that the department will deal with them because they exist but the officials consistently cite the Health Regions legislation (*The Regional Health Services Act*, Chapter R-8.2* of The Statutes of Saskatchewan, 2002 as amended by the Statutes of Saskatchewan, 2002, c.C-11.1; 2003, c.25; 2004, c.49; 2004, c.51; 2004, c.C-11.2; and 2005, c.M-36.1) as setting out the mandate they must implement.

Through their multidisciplinary approach to care, the Clinics provide access to a wide range of health care services and programs not normally offered by private practitioners; they also provide access to many programs and services in one physical location. The Clinics go further to advocate and lobby on their members' behalf and to address the social determinants of health, not only the immediate and acute care needs. Their focus on health promotion and prevention, rather than the medical model of care, enables them to address multiple problems at the same time. Still, there are differences of opinion among Clinic informants about how successful the Clinics are in achieving a multidisciplinary approach:

Informant: Just because you put all of these health professionals in one building doesn't necessarily mean that the service delivery model is one where they're all co-operating with each other and each is working to their full capacity. Although I have seen many instances within the community clinics where they have, I have also seen many instances where they haven't. So you've got doctors, you've got a nutritionist, an occupational therapist, physiotherapist, pharmacist and whether they are all interacting the way they should to the best interest of the patient (Transcript 36).

One informant expressed the view that because the Clinic's founder was a doctor, the Clinic was still dominated by the medical model of health care, a model in which people are treated after they become ill or injured. Moreover, this informant did not view the Clinic as having a "true" multidisciplinary team (Transcripts 9, 35). The multidisciplinary approach is frequently claimed as a key distinguishing feature of the Community Clinics; it differentiates them from private medical practice and from some public health facilities.

This is problematic because government officials do not appear to distinguish between the co-operative Community Clinic model and private medical practice. Instead, government officials hold the Clinics to the same standards as private practice and do not appear to understand the multidisciplinary approach the Clinics try to implement. Officials in the Department of Health regard the Clinics as anomalies and Health Region informants point to the difficulty of controlling autonomous entities with their own boards of directors:

Clinic Informant: The bureaucracy wants a system they can control. They can't control the Clinics. They view them as problems. The Clinics don't fit into boxes (Transcript 42).

Health Region Informant: ... you know co-operatives by their very nature impose another set of challenges because it is a co-operative and democratic; there's less control (Transcript 40).

Health Region Informant: So the community clinics basically have been more independent and autonomous and have done their own assessment and planning and they've come up with an agenda and they want us to buy it. And our strategy has been more one of, we need to develop a common strategy and agenda based on a whole host of competing interests. Partner with us and we'll come up with one that's in common. I think what we sometimes have is a polite, friendly but bit of an arm wrestle around whose autonomy is whose—Are we in the lead? (Transcript 11).

The global funding that the Clinics receive from the government is still based on fee-for-service remuneration. Moreover, instead of being allowed to allocate funds to reserves for future expenditures on necessary equipment, staff and other expenses, the Clinics are also required to return any “surpluses” they may achieve through operational efficiencies (Transcript 1).

Although the literature suggests that governments sometimes view co-operatives as playing a check and balance or competitive yardstick role, the idea that the Clinics do so actually was put forward by a Clinic informant (Transcript 32) but not from any of the politicians, government officials or health region officials interviewed. One Clinic informant alluded to this role when discussing the reasons for the government to keep supporting the Clinics. Noting that the health care system seems to have caught up to where the Community Clinics have been for over forty years, the informant speculated that the government maintained the Clinics to “tweak” the system and that the Clinics play a “check and balance” role (Transcript 11).

It may be that the check and balance role was stronger in the past. The politicians have said repeatedly that the Community Clinics were instrumental in bringing the doctors’ strike to an end in 1963 and they were key in getting Medicare off the ground (Transcripts 24, 32). The establishment of the Community Clinics demonstrated to the medical establishment that the residents of the province could organize themselves into co-operatives to obtain physician services under salary or contract in a publicly-funded scheme. This effectively showed that there was a viable alternative to private insurance and fee-for-service private practice. It is generally believed that the Clinics helped the government achieve its public policy goal of establishing Medicare (Transcript 24; Rands

1984). Although only a few Community Clinics remain, their continued existence could well serve as a reminder to the medical establishment that the government has options for the organization of primary health care services. If this were the case, the government's use of the Community Clinics in this fashion would make them a policy instrument of the government.

However, the evidence to support the proposition that the Community Clinics play a check and balance or competitive yardstick role is somewhat slim. Further, the data do not indicate what public policy role, if any, the government believes the Community Clinics now play. It is only inferred by political informants that the Clinics played this role in 1962 (Transcripts 24, 32).

6.1.2 Proposition Two

Co-operatives can be expected to have little influence on government policy, except where their ability to act as a check and balance or competitive yardstick may address government priorities.

With respect to Proposition Two, there is evidence in the data to show that government officials lack knowledge and understanding of the co-operative model and that when they do receive attention from officials, co-operatives are treated much like any other enterprise. The evidence confirms what was suggested in the literature (Hammond Ketilson and MacPherson 2001; Hammond Ketilson et al. 1992; Fairbairn et al.1993). The co-operative form of organization has often been overlooked in the design and delivery of government programs and services (Fairbairn 2001). Similarly, there is evidence that government officials lack knowledge and understanding of the Community Clinic model (Transcripts 15, 27). This may explain, in part, why the Clinics have not

been effective in their lobbying and advocacy efforts. Coupled with a lack of unity, it may also help to explain why they have not been able to play a stronger role in health reform, and why they have never been able to persuade government to pass separate enabling legislation specifically for the Clinic model. Interviewees testified that the legislation that allowed them to form originally (*The Mutual Medical and Hospital Benefit Associations Act*) will be discontinued. What will remain is *The Co-operatives Act, 1996*, which has little content on Community Clinics, and, as discussed in Chapter Two, is largely based on corporate legislation.

There is evidence to suggest that government's policy toward the Community Clinics could be categorized as level 2 on Hoyt's continuum (see page 38), as discussed in Chapter 2. At this level, the government "does not actively attempt to destroy co-operatives but neither does it give them special treatment." Hoyt (1989) labels level 2 as "neutral", with government having no public policy toward co-operatives, either negative or positive. The government's inaction is its policy. It does not actively oppose or suppress the Community Clinics, as are governments at level 1 on the continuum. Nor does it actively support the Community Clinics as at level 3, where governments do pass special legislation to make it easier to organize and operate co-operatives, and provide other supports for co-operative development. Generally, the provincial government in Saskatchewan seems to be conflicted about supporting the active development of co-operatives (Fairbairn 2001), let alone Community Clinics.

Hoyt's level 2 accommodates the minimum action needed to maintain the co-operative Community Clinics. Some Clinic informants might view level 1, which Hoyt labels "destructive", as more indicative of the government's policy toward the

Community Clinics, especially with respect to their dealings with Department of Health officials and their lingering beliefs about the Saskatoon Agreement (Transcripts 42, 5, 37). There is considerable evidence to show that the Community Clinic informants believe that they have not received adequate and consistent support from the government over time, and further that government policy, programs, legislation, budget allocations and organizational structure have not been what the Community Clinics needed (Transcripts 1, 2, 42, 41, 16, 28).

Evidence from the case study and other data sources shows that, although some politicians have been viewed as supportive, access to Cabinet Ministers and senior officials has been limited. Much of the support that has been offered, other than the annual global funding, has been largely ceremonial. The Clinics have been unable to infiltrate the policy-making process with respect to health care policy in Saskatchewan.

Even though its policy is one of not providing additional or preferential resources, the government may continue to support the Clinics because it sees some value in maintaining at least the perception that it still has goals in common with those of the co-operative movement. Although Fairbairn (2000) has argued that government support of the co-operative movement varies with its policy goals and priorities, the movement still has a strong economic and social presence in the province, as demonstrated by Hammond Ketilson et al. (1998) and Herman and Fulton (2001). In total, Saskatchewan residents hold over 1,000,000 memberships in co-operatives and credit unions in the province; and many residents have memberships in more than one co-operative or credit union. And, as Doern and Phidd (1992) and Stanbury (1993) point out, governments want to be elected

and re-elected. “Showing the flag”⁸ may serve partisan political interests if it is perceived to influence votes. Maintaining the Community Clinics may also show support by the government for Medicare itself. Indeed, a Clinic supporter said that the government would keep the Clinics around because of their connection to Medicare (Transcript 12); more than one felt that the Clinics should be afforded special treatment because of this, even though that special treatment has not manifested itself.

6.2 Prospects for Policy Change

Propositions Three and Four were developed from the literatures reviewed in Chapter Three on the social economy in Canada, the role of ideas and ideology in policy-making, interest group-government relations, and conceptualisations of power in the relationship between the social economy and the state, as reviewed in Chapter Three.

As noted in Chapter Four, the policy environment in which the Community Clinics exist is complex, with a number of relationships at play that, in turn, affect the relationship between the Clinics and the provincial government. The actors in the process include provincial Cabinet Ministers and MLAs, Department of Health officials, Health Region officials, the medical establishment, the co-operative movement, the Federation, the individual Clinics and the Clinics’ members. Differences in views and goals among all of these actors add to the complexity facing the Clinics.

⁸ The Government of Saskatchewan recognizes the co-operative sector annually in October during Co-operatives Week. The week begins with a ceremonial flag-raising of the co-operatives flag at the Legislative Building (<http://www.gov.sk.ca/news?newsId=ed0e0d49-f1a0-4d48-9e66-7a8a11b0d389>).

6.2.1 Proposition Three

Achieving major changes in government policy towards co-operatives will be difficult, unless co-operatives have some resources to offer to government. The more valuable the resources that co-operatives can offer to government, the more power co-operatives will hold in the relationship.

With respect to Proposition Three, the literature on public policy and policy-making suggests that the actors who control significant resources will be more successful in meeting their own goals (Doern and Phidd 1992). The actors in the government have resources that interest groups want; in order to get those resources, interest groups must have resources that the government wants to harness or access (Stanbury 1993). Evidence from the data suggests that the Community Clinics hold little power or control in their relationship with the provincial government, and that the resources they do have are no longer viewed as essential or crucial.

Although the Community Clinics continued to receive core funding from the Department of Health, the restructuring of the institutional structure of health care has resulted in a redistribution of power and control to the Health Regions. The Community Clinics have been afraid of losing their autonomy ever since the Health Regions were established. They have been told that they will be folded into their respective Health Regions when the regions were able to assume responsibility for primary health care, including alternate payment arrangements for a majority of individual and group practices in the Regions (Transcripts 1, 21; 1993-94 Annual Report). The Community Clinics' relationship with the provincial government was changed so that the Clinics had to obtain funding for additional programs and services from the Health Regions, instead of directly from the Department of Health. As discussed in the previous section, the

Health Regions and Department of Health officials want to control the Clinics; the co-operative model under which they operate is viewed as a liability (Transcripts 11, 40, 42).

The Community Clinics represent a valuable resource in their ability to innovate. As noted previously, the Clinics innovated to serve the needs of their members and many of their innovations were adopted at provincial and national levels (e.g. the prescription drug plan that was adopted by the provincial government). The literature on the role of the social economy suggests that social economy organizations such as co-operatives have been and still are sites where innovative social programs and services can be created, refined, incubated and then diffused more broadly (Goldenberg et al. 2009; Bouchard 2009). Evidence from the field interviews suggests that the Clinics can be such a “speedboat” in innovation (Transcript 32). However, there is no evidence in the data collected and reviewed for this study to show that the government recognizes the Clinics’ record of innovation.

6.2.2 Proposition Four

Co-operatives will expect equitable relationships with government and the co-construction of public policy as it affects them, but will not be successful. The underlying ideas and ideologies of the government and other key actors in a policy field will often prevent this.

The relationships that are desired are determined by the underlying ideas and ideologies of the actors involved in the complex web that is the health care policy domain (Stanbury 1993; Hall 1993; Doern and Phidd 1992). Evidence drawn from the field data illustrates the dominant ideas or paradigms that influence the behaviour of the actors in the health care policy domain in Saskatchewan. For the Health Regions, the dominant ideas are encapsulated in the legislation by which they were established:

Health Region Informant: ...we are responsible for delivering the comprehensive array of health care services. It is our job to integrate, plan and provide that kind of leadership. And do we've been mandated to do that and that's how we try to work (Transcript 11).

Health Region Informant: I think the concern that I would have is that it does need to be part of an integrated system. The regional structures are intended to promote, enable, create integrated health systems (Transcript 40).

Ideas related to regionalization, centralization, and integration, as mandated by the provincial government, have become significant driving forces for the Health Regions. Their strategies are to achieve greater centralization and integration.

Aside from the Saskatoon Agreement, the government's policy appears in other forms. It appears in the government's annual expenditure budget; the service agreements between the Department of Health and the Community Clinics; the quarterly reports required by the Department of Health; the requirement that the Community Clinics obtain additional funds from the Health Regions for new programs and services; the requirement that the Community Clinics co-ordinate their plans with those of the Health Regions; the government's intention to repeal *The Mutual Benefit and Hospital Associations Act*; the government's continued inaction with respect to the Clinics' request for specific legislation; and the government's lack of support for the development of new Community Clinics (Transcript 1).

The government's policy also appears in the legislation establishing the Health Regions (*An Act respecting Regional Health Services*). Regionalization is the government's chosen policy instrument in the reform of the health care system in Saskatchewan. The institutional structure of the health care system having been reformed, the government has more recently turned its attention to addressing primary

health care (*The Saskatchewan Action Plan for Primary Health Care 2002*), for which the Regions have responsibility. Department of Health and Health Region officials repeatedly referred to the Health Region legislation as the mandate for health care delivery in Saskatchewan (Transcripts 13, 11, 40). It is almost a mantra — adherence to this mandate is the prime directive. In aggregate, these elements add up to the government's policy on the Community Clinics; in short, tolerate the existing ones while also avoiding open or overt actions to bring about their demise.

The creation of the Primary Care Branch in the Department of Health made the Clinics more visible to the government, but also brought to the fore ideas about accountability, and administrative and planning processes. More rules regarding accountability and problems in administrative and planning processes resulted (Transcripts 9, 35). For instance, it is difficult for the Clinics to plan because Department of Health officials do not let them know what their funding will be until after a new fiscal year has started.

In contrast to the dominant ideas of regionalization, centralization and integration that are embraced by Health Regions and the government, the Community Clinics, in general, focus on ideas of autonomy, independence, democratic governance and community-based control, all of which are rooted in co-operative philosophy (Transcripts 1, 11, 12). The different ideas of the Health Regions and the Community Clinics thus bring these two actors in the health policy domain into conflict. Differing ideas within and among the Clinics with regard to advocacy and lobbying exacerbate the challenges they have in presenting a coherent argument to the provincial government to increase their role in the delivery of primary health care services.

Differing ideas within government (i.e., those held by politicians, department officials, Health Region officials) also contribute to the complexity of the relationships among the actors in the health care policy domain. Evidence from the interviews revealed that some political informants blame officials for not giving the Community Clinics an increased role in the health reform process (Transcript 22); Clinic informants believe that the politicians told department officials to “leave the clinics alone” but the officials took this to mean that they should let the Clinics exist and continue to fund them but otherwise ignore them (Transcript 1). As noted previously, the politicians show ceremonial support but Department of Health officials continue to regard the Community Clinics as anomalies.

The government’s private sector orientation, as seen in co-operative legislation based on corporation law and its failure to distinguish co-operatives from private sector business (Axworthy 1990; Canadian Co-operative Association 2009), has perhaps contributed to the dominance of the medical establishment and its influence with respect to the continuation of fee-for-service remuneration. The medical establishment has considerable resources to devote to lobbying and advocacy, as well as longstanding close relationship with Department of Health officials (Transcripts 15, 27).

Examination of the case study materials and the analysis of the provincial government’s relationship with the Community Clinics reveal the important roles of some ideas that are in circulation. These include regionalization, centralization and integration, all of which can conflict with core ideas of the Community Clinics. These include with respect to autonomy, democratic governance, and member-ownership and

control. The government's chosen policy instrument of regionalization has been the force behind the push to centralization and integration.

The dominance of these ideas suggests that a third order policy shift (Hall 1993) would have been, and would still be, necessary in order for the Community Clinics to achieve what they have regarded as their proper place in health reform and the delivery of primary care. The historical conditions which would have promoted or allowed a third-order policy shift in the Clinics' favour – changes in the dominant paradigm, in its instruments and in their settings – did not appear to exist during the period of time under examination in this research. Instead, a third order policy shift addressed the need for institutional restructuring and rationalization of the hundreds of health care organizations operating in the province, each with their own boards. There is also evidence from the field data that a change in government from the Progressive Conservatives to the New Democratic Party in 1991 did not result in the paradigm shift that the Community Clinics had hoped for (Transcript 1).

Ironically, the government has been attempting to effect a change from fee-for-service remuneration of physicians to other methods such as capitation or salary; the Community Clinics have close to fifty years of experience in remunerating their physicians by salary or contract. However, there is evidence from the interviews and from other sources that the medical profession still favours fee-for-service payment (Transcripts 1, 14), although some doctors, especially younger ones, may consider alternate forms of payment (Transcript 28). Nonetheless, fee-for-service remuneration remains the dominant idea and paradigm for a medical profession that has been slow to embrace any changes in their payment arrangements.

The government's other important policy instrument – the Saskatoon Agreement – represents a historical third-order policy shift, changing as it did the means through which citizens of the province were insured for health care. The introduction of publicly-funded health insurance was a defining moment in the province's history and set the precedent for national programming that has come to symbolize what it means to be Canadian. As mentioned above, ambiguity about the intention and effect of the Saskatoon Agreement persist.

The treatment that the Community Clinics have received suggests that they hold little power in the relationship and that they do not have resources that the government wants. The Community Clinics have sought to participate in the development of primary health care policy in Saskatchewan over a long period of time but there is little likelihood that a paradigm shift will occur. Private practice and fee-for-service remain the dominant paradigms in health care delivery in the province. Evidence from the field interview data reveal that there is no political will to pursue a major policy shift with respect to the Community Clinics (Transcript 21).

6.3 Summary

Assessment of the propositions in light of the case study data reveal only partial support for Proposition One and little support for Proposition Two. With respect to Proposition One, Clinic founders and the government have differing views on the role of the Community Clinics, but so too, it seems, do Clinic founders and some other Clinic actors. The Community Clinics are unique as a group but also cannot be addressed as an entirely homogenous group, given the internal differences that emerged. Differing views

of the Community Clinics, whether expressed by politicians, Department of Health officials, Health Region officials, Clinic founders, current Clinic informants, and others, pose additional significant challenges to adequately conceptualizing them. Lack of homogeneity can limit co-operatives' effectiveness in policy-making and advocacy efforts (Fulton and Laycock 1990); lack of homogeneity among the three Community Clinics may reduce their effectiveness with respect to influencing the provincial government.

Considering Proposition Two, there is nothing in the field data to indicate that the government values the resources that the Clinics possess, and no indication that the government believes that the Clinics play a check and balance or competitive yardstick role in the delivery of primary health care in the province. Government's policy on the Community Clinics can be placed at Level 2 on Hoyt's continuum; Hoyt (1989) labels level 2 as "neutral", with government having no specific public policy targeting co-operatives, either negative or positive.

In assessing evidence in relation to Propositions Three and Four, it becomes apparent that achieving a major or third-order paradigm shift would be very difficult. The Community Clinics, while expecting to play a role in the delivery of health care in the province, have been denied access and participation, and have not been able to co-construct public policy. The dominant paradigms of private medical practice with fee-for-service remuneration, and integration, regionalization and centralization, seem firmly entrenched.

What does this mean for how the relationship between the Community Clinics and the provincial government can be conceptualized and understood? The following

chapter explores more implications flowing from this assessment of the propositions, offers some possible answers to the research questions, and suggests directions for future research.

CHAPTER SEVEN: CONCLUSIONS: TOWARD A NEW UNDERSTANDING

7.0 Introduction

The relationship between Saskatchewan's co-operative Community Clinics, as hybrid social economy organizations, and the provincial Government of Saskatchewan has been the focus of this study. In spite of a seeming congruence between the goals of the Community Clinics and successive provincial governments, the Clinics have not played a significant role in reforming the delivery of primary health care services in the province, even though they played a key role in bringing the doctors' strike of 1962 to a conclusion. The Clinics' role enabled the provincial government to proceed with the establishment of the publicly-administered health care insurance scheme that was subsequently adopted nationally and became known as Medicare — a defining feature of what it means to be Canadian.

When the NDP government made sweeping changes to the institutional infrastructure of health care in Saskatchewan beginning in 1991, the Community Clinics were not invited to participate, even though they desired an increased role in the new system. This seemed to be a reasonable expectation because the Community Clinics had decades of experience in providing primary health care services through interdisciplinary teams, alternate forms of remuneration for doctors, a focus on health promotion and prevention, and the provision of multiple health care programs and services in one location. Their approach was patient-focused and members had the opportunity to participate more actively in their own health care. Many of the key features of the Community Clinics were congruent with the expressed goals of the government, but the Clinics have not been successful in securing a place at the health care policy table.

This study sought to examine this paradox with specific focus on the following research questions:

- What role do ideas and ideology play in the policy-making process related to the co-operative Community Clinics?
- Under what conditions can the dominant paradigm in health policy, specifically regarding the co-operative Community Clinics, be changed?
- What accounts for the ambiguity in the relationship between the Clinics and the government?

The literatures on the roles of social economy organizations and co-operatives in society, co-operative-government relations, interest group-government relations, public policy and policy-making processes, and the role of ideas and ideology in public policy informed the development of propositions about important dynamics in the relationship between the Community Clinics and the provincial government. The four propositions that arose from the literature are:

Proposition One:

The views of the government and those in the social economy can differ and conflict. While co-operative founders believe that the co-operative model of social economy organization allows their members to achieve control over the delivery of the goods and services they need, with the underlying ideology promoting a vision of a better society, government believes that co-operatives serve a public policy role by acting as a check and balance and serving as a competitive yardstick to the private sector.

Proposition Two:

Co-operatives can be expected to have little influence on government policy, except where their ability to act as a check and balance or competitive yardstick may address government priorities.

Proposition Three:

Achieving major changes in government policy towards co-operatives will be difficult, unless co-operatives have some resources to offer to government. The more valuable the resources that co-operatives can offer to government, the more power co-operatives will hold in the relationship.

Proposition Four:

Co-operatives will expect equitable relationships with government and the co-construction of public policy as it affects them, but will not be successful. The underlying ideas and ideologies of the government and other key actors in a policy field will often prevent this.

This chapter offers some possible explanations for the paradoxical relationship between the Community Clinics and the government. The implications of the propositions are discussed first, with the propositions grouped according to the streams of literature examined. Propositions One and Two arose from the literature on the social economy in Canada, the role of co-operatives in society, and co-operative-government relations; Propositions Three and Four arose from the literature on policy processes and public policy-making, including the roles of ideas and ideology and interest groups. Adaptations to Stanbury's (1993) framework for understanding business-government relations are suggested to address the context of primary health care service delivery and the relationship between the Community Clinics and the provincial government of Saskatchewan. Possible answers to the research questions are then discussed, and the basis for a new understanding of the relationship between the Community Clinics and the provincial government is elaborated. The chapter closes with possible directions for future research.

7.1 Implications of Propositions One and Two

Proposition One:

The views of the government and those in the social economy can differ and conflict. While co-operative founders believe that the co-operative model of social economy organization allows their members to achieve control over the delivery of the goods and services they need, with the underlying ideology promoting a vision of a better society, government believes that co-operatives serve a public policy role by acting as a check and balance and serving as a competitive yardstick to the private sector.

Proposition Two:

Co-operatives can be expected to have little influence on government policy, except where their ability to act as a check and balance or competitive yardstick may address government priorities.

The field data together with other documentary evidence support Proposition One and appear to indicate that the Community Clinics do not have resources of value to the provincial government such that they would be able to achieve access to and influence policy-making. There are significant differences between the views of the government and the founders and some current Community Clinic informants. The analysis has also shown that there are significant differences among the three Clinics Community Clinics and they cannot be conceptualized as a homogenous group. Notwithstanding their differences, their commonalities make them unique organizations among co-operatives.

That very uniqueness suggests that the Community Clinics may not be sufficiently conceptualized as social economy organizations, as co-operatives or as public service providers. The Clinics can be viewed as hybrids of all three types of organizations – social economy, co-operative and public sector. The confusion around definitions and understandings of co-operatives and the social economy also constrain how they are conceptualized. Lack of a clear definition and understanding could help to explain why the government does not appear to think that the Clinics currently have a

defined public policy role, and fails to distinguish them in some respects either from private doctor-run clinics or from public health clinics and hospital facilities.

As co-operatives, the Community Clinics have been established under the relevant co-operative legislation, generally adhere to co-operative principles, and observe democratic governance practices. What separates them from other co-operatives is their almost complete dependence on the provincial government for their funding. The Clinics thus cannot be fully conceptualized as co-operatives. Nor can they be fully conceptualized as public sector entities, even though they receive almost all of their funding from the government and deliver a public service. They are also not private sector organizations, although they do appear to be conceptualised by the provincial government as another form of private practice. It appears that the North American literature on co-operative sector-government relations does not and cannot adequately address the attributes of the co-operative Community Clinics. The public policy role(s) that the Clinics play cannot be adequately defined because they are rather special kinds of hybrid organizations.

The literature on the social economy in Canada better enables the Community Clinics to be conceptualised or re-conceptualised as hybrid organizations. Fairbairn (1997) states that the co-operative Community Clinics played a key role in the establishment of the country's public health care system: "The development of 'community clinics' was an integral part of the development of the Medicare program" (Fairbairn 1997: 6). The definition proffered by Bouchard, Ferraton and Michaud (2008) applies to the Community Clinics as social economy organizations in all respects: they focus on providing services to their members and the community and are not profit-

oriented, they are in many respects autonomous organizations, they follow a democratic decision-making process, revenues and surpluses are utilized to maintain and improve service provision, and they generally encourage the participation and empowerment of their members and community. This research shows that it is because the Clinics do all of these things that the government finds them challenging to deal with.

7.2 Implications of Propositions Three and Four

Proposition Three:

Achieving major changes in government policy towards co-operatives will be difficult, unless co-operatives have some resources to offer to government. The more valuable the resources that co-operatives can offer to government, the more power co-operatives will hold in the relationship.

Proposition Four:

Co-operatives will expect equitable relationships with government and the co-construction of public policy as it affects them, but will not be successful. The underlying ideas and ideologies of the government and other key actors in a policy field will often prevent this.

Propositions Three and Four arose from the literatures on public policy and policy-making processes, and the role of ideas and ideology and of interest groups in public policy. Stanbury's (199) framework is based on public choice theory, where government seeks to gain and retain political power as the governing party, and interest groups seek a favourable legislative and regulatory environment. Each has something the other wants, resulting in a bargaining context where there can be an exchange of resources. There is evidence that in some respects the provincial government considers

the Community Clinics to be like any other private sector medical business. Power lies in the hands of the government for the Clinics' global budget allocations, and with the Health Regions that control resources for additional programs and services that the Clinics may wish to offer.

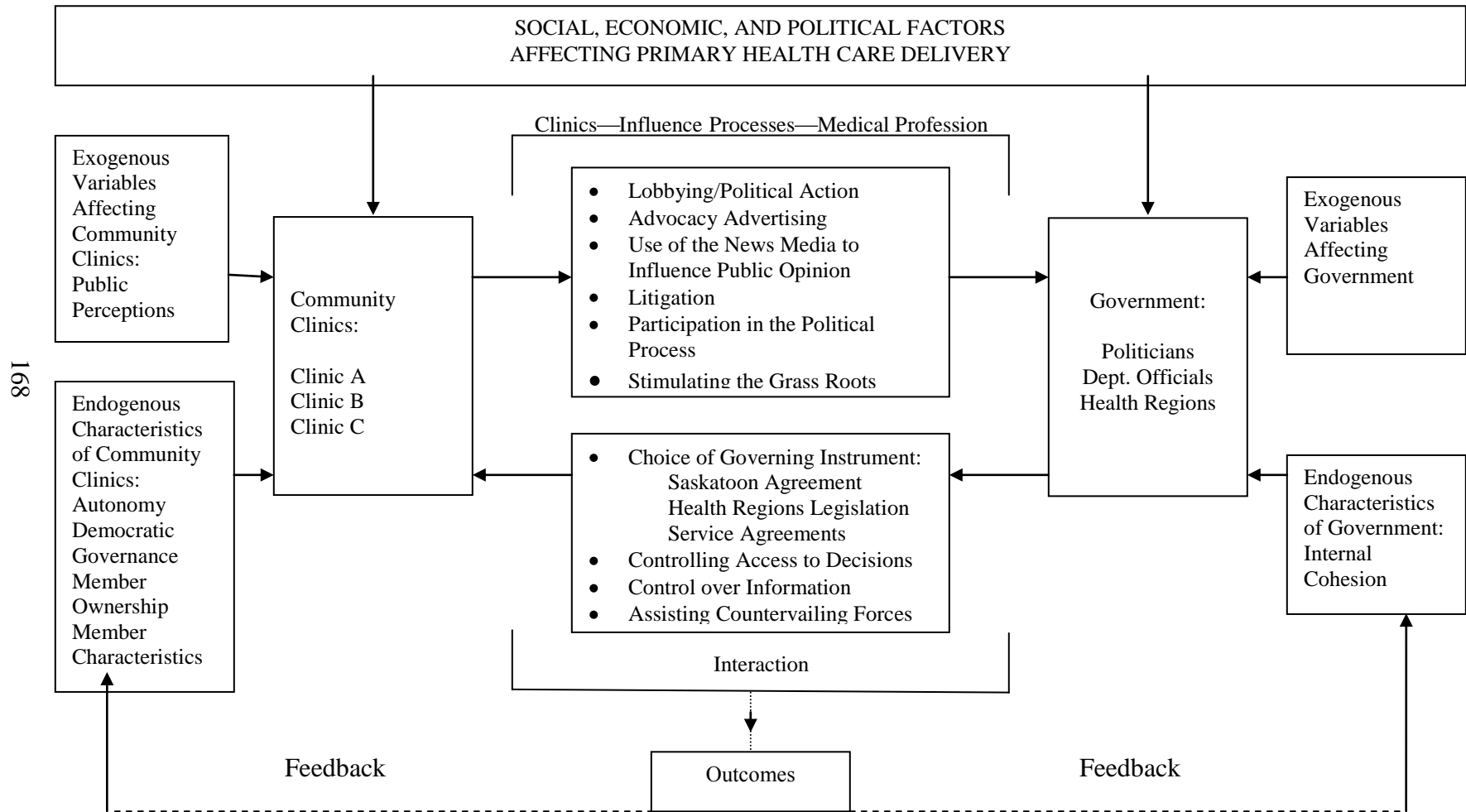
Stanbury (1993) adopts a positivist approach to understanding the relationship between interest groups and government. His work is based on observations of this relationship. Vaillancourt (2008), on the other hand, has adopted a normative approach in describing how the relationship between social economy organizations and government should unfold. There is some commonality between Stanbury and Vaillancourt with respect to the importance of openness in the relationship between interest groups and government, and the role that interest groups play in democracy. When Stanbury (1993) speaks of openness, what he means is that the relationship between interest groups and government should be “well and widely understood”, and capable of accommodating new or emerging interests “so that change can occur without severe discontinuities”. In this instance, the relationship between the Clinics and the government does not appear to be well and widely understood. Maintenance of individual freedom and democracy are important to both Stanbury and Vaillancourt. Stanbury (1993) refers to it as an evaluation criteria relating to how government intervention affects individuals' choices, speaking to the pluralistic, liberal values that he sees as underlying the political system and where the balance of power lies. Stanbury notes that “persistent dominance by any interest group, including government, [must] be avoided if we are to aspire to a genuinely pluralistic, democratic society” (Stanbury 1993: 41).

Vaillancourt's (2008) conceptualization of power in the relationship between social economy organizations and government differs significantly from Stanbury's with respect to interest groups and government. While Stanbury (1993) depicts a relationship with winners and losers, conclusions arising from Vaillancourt's (2008) conception of the state are that policy-making is, at least potentially, a collaborative process in which all stakeholders have equal access and participate on the same level. In Quebec, at least, the provincial government partners with stakeholders from the private sector but has also begun to partner with those from the social economy. Government decision-makers have established open, inclusive dialogue between themselves and the leaders of social economy organizations, and these organizations are not just instruments of the state in implementing public policy. In Stanbury's terms, the relationship as conceived by Vaillancourt would be win-win for both parties.

Evidence from the field data shows that policy-making by provincial governments in Saskatchewan has not been a collaborative process in which the Community Clinics have had access and participated at anything near the same level as the medical profession. Government decision-makers do not seem to have established open, inclusive dialogue between themselves and the leaders of the Community Clinics or their Federation. There is evidence to show that the Community Clinics are co-producers of primary health care services, but are not co-constructors of primary health care policy. Vaillancourt's (2008) somewhat idealized conceptualization of social economy-government relations does not reflect the reality of the relationship between the Community Clinics and the government of Saskatchewan.

Because Stanbury's framework focuses on business-government relations in Canada, it is necessary to make some adaptations more appropriate for the study of the relationship between the Community Clinics and the provincial government in the context of primary health care delivery. The framework does not address the degree of internal cohesion within the government; in the primary health care context of Saskatchewan, the elected politicians, Department of Health officials and Health Region officials are all actors that often have differing views. The medical profession is also an actor possessing considerable resources and influence in this context. The framework requires that the medical profession's influence processes be taken into account. The exogenous variables and endogenous characteristics of business trade associations and lobby groups must also be adapted to better represent those of the Community Clinics. Indeed, Stanbury's interpretation of these terms differs from what they are normally understood to mean, as discussed in Chapter Five. A modified framework to address these concerns is provided by Figure 5 (page 163)

Figure 4 A FRAMEWORK FOR UNDERSTANDING COMMUNITY CLINIC-GOVERNMENT RELATIONS IN SASKATCHEWAN



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Adapted from Stanbury 1993

7.3 The Role of Ideas and Ideology

The study has shown that there are a large number of clashing and conflicting ideas and ideologies at play in the relationships among all of the relevant actors that serve to complicate the already complex. The actors and some salient ideas are depicted in an expanded diagram of the health policy domain prepared by the author (see Figure 4).

In this diagram, the dominant ideas and ideologies associated with each actor in the Health Care Policy Domain in Saskatchewan are depicted. These ideas and ideologies were identified through analysis of the case studies of the Clinics, the transcripts of the key informant interviews, and other primary and secondary sources from and about the Community Clinics. The Government of Saskatchewan sits at the top of the diagram because of its overall responsibility for provincial health care policy; as demonstrated in this study, the politicians appear to subscribe to notions that the private sector should be the dominant form of enterprise with which it deals. In the health care policy domain, this translates into maintenance of the fee-for-service method of remunerating doctors while providing ceremonial support to the Community Clinics.

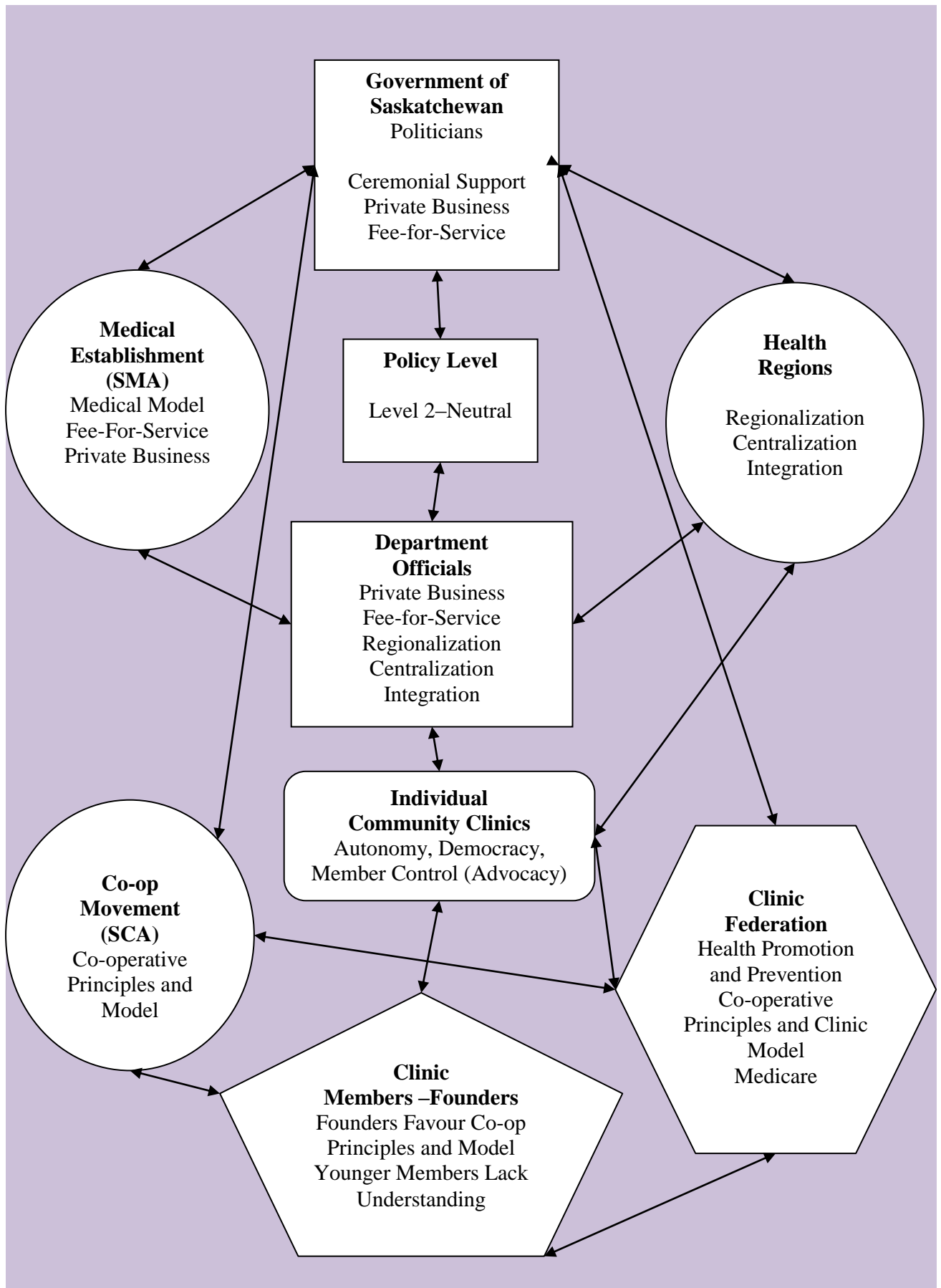


Figure 5 – Dominant Ideas and Ideologies (prepared by author)

The medical establishment's influence still dominates the health policy domain in Saskatchewan with respect to maintaining the hegemony of private medical practice with fee-for-service remuneration. It appears to a large degree to be still operating in the medical model of treating patients when they become ill or injured, and that many doctors still wish to operate essentially as private businesses. Department of Health officials have had a stronger relationship with the medical profession than they have had with the Community Clinics, and the medical establishment has lobbied hard and effectively to support the dominant paradigm. In spite of efforts to negotiate and implement new ways of remunerating doctors (e.g. salary, capitation, contract), department officials have not yet been able to persuade the medical establishment to accept any such alternatives.

Department of Health officials are also pushing forward the governments' agenda with respect to the Health Regions; hence the attachment of ideas around regionalization, integration and centralization to actors in the Health Regions. This has placed the Health Regions into conflict with the Community Clinics. Ideas around autonomy, democratic governance and member control are important to the Community Clinics, although two of the Clinics appear to more closely adhere to these ideas. These are the two that favour taking political action to influence the government. Differences among Clinic founders and members emerged from the analysis, with many younger members lacking knowledge and understanding of the co-operative model. The Federation advocates for and promotes a health promotion and prevention model, co-operatives principles and the Community Clinic model of primary health care delivery, while also lobbying for the continuation of Medicare itself. The co-operative movement in Saskatchewan, as represented by the

Saskatchewan Co-operative Association, advocates for the co-operative model in all aspects of the province's economy and society.

Finally, the policy level that sits between the political level of the government and the department officials is shown in the diagram as Level 2 – neutral. The history of the provincial government's treatment of co-operatives generally, and the Community Clinics more specifically, has shown that this complex and conflicting web of actors, ideas and ideologies, has shifted and changed over time but not to the benefit of the Clinics.

There are tensions between ideology and ideas that appear to get in the way of advancing the ideas that are shared. The government and some doctors have shown interest in advancing health reform to the next stage – that of reforming the delivery of primary health care. This stage would see a shift to a health promotion and prevention model, different means of remunerating doctors, and more patient involvement in her own health care. These are ideas that the Community Clinics have acted on for well over forty years. Yet, the old ideas around the medical model combined with an ideology that favours the private sector appear to stand in the way of achieving progress on this front.

The government has shown ceremonial support for co-operatives and the Community Clinics but the Clinics have few resources with which to bargain effectively with governments; thus, they have not been able to play a public policy role, even in the period in which the NDP was last the majority party in government. Their lack of resources combined with the inability or unwillingness of the elected members of government and department officials to reconceptualize the Clinics as important sources of primary health care innovation leaves Community Clinics with

little power or control over their relationship with the government, department officials and Health Regions.

7.4 Conditions for Policy Change

As discussed in Chapter Three, Hall (1993) states that the conditions under which a major policy change could occur include a major paradigm shift, as well as changes and adjustments to the policy instruments and the ways they are implemented (Hall 1993; Scogstad 2000). The conditions under which support for the Clinics could change did not exist when the NDP was the governing party from 1991 to 2007. When it returned to power in 1991, its priority in health care was to reorganize the institutional infrastructure. This in itself represented a major paradigm shift but was not one that included a role for the Community Clinics. Other changes and adjustments to the policy instruments led to the establishment of Health Districts, which later became Health Regions. Reforming the delivery of primary health care services became a priority only much later in the NDP's tenure as the governing party. Whether a change in governing party would alter the dominant paradigm in the health care policy domain is not known.

Political parties in Saskatchewan have changed considerably since the Community Clinics were established. The Liberal Party does not have any elected Members of the Legislative Assembly (Legislative Assembly of Saskatchewan website). The former Progressive Conservative Party, together with some former Liberals and Reform Party supporters, became the Saskatchewan Party in 1997 which subsequently won the provincial election held on November 7, 2007. Although the Saskatchewan Party's 2005 Policy Guide (Saskatchewan Party website) said the party supports a publicly-funded and administered health care system for the province, it

also says that the Health Regions “have not led to the delivery of better front line services. In fact, they’ve created impediments to the effective province-wide use of the province’s health facilities and human resources”. The Saskatchewan Party’s 2005 Policy Guide proposed establishment of a “single health care agency for the entire province that would fully utilize the province’s health facilities and human resources”.

At the time of writing, the Saskatchewan Party’s website refers to a document with “new ideas for Saskatchewan” (Saskatchewan Party website); this document does not mention a single health care agency as proposed in the 2005 Policy Guide. It is not evident that the change in governing party will significantly affect the Community Clinics. If centralization is the Saskatchewan Party’s chosen public policy instrument, the Community Clinics could find themselves in a precarious position. The Clinics are still perceived to be the creatures of the NDP. This legacy together with the neoliberal political ideology may have a great deal to do with the future of the Clinics

7.5 Sources of Ambiguity in the Relationship

The sources of ambiguity in the relationship between the Community Clinics and the provincial government are many. They include the different conceptualizations of the Clinics, including those of the politicians, department officials and Health Region officials. Lack of political will combined with ceremonial acknowledgement of the Clinics by the politicians is another source. There are also lingering misgivings and misconceptions about the Saskatoon Agreement. Despite the different views held by informants within and among the Community Clinics, it is the views of those on the outside that have had the biggest

impact. The study has revealed that department officials regard them as anomalies that they would rather not have to deal with; that Health Region officials want to gain more control over them; and that the politicians “wave” the flag” but provide only what is required to maintain the Clinics.

There is the uncertainty caused by the NDP government’s previously-stated intentions to roll the Clinics into the Health Regions, providing the latter make progress in implementing alternate remuneration schemes for doctors. The most recent agreement for fee-for-service with SMA covers the period of 2006-09. If progress is made toward moving other doctors in the province into group practices with alternate means of remuneration, would the government continue to (barely) maintain them? If the government thought that the Community Clinics were serving as a “check and balance” instrument, this role would no longer be required in the event that doctors agreed to work under contract or salary arrangements. Progress has been slow with respect to negotiating a new agreement between the Saskatchewan Medical Association and the government and it seems unlikely that the government will make progress toward achieving its stated primary health care goals in the short term. This rationale for keeping the Clinics going could eventually disappear. The governing party has changed since the Clinics were made aware of this possibility and, as discussed, the views and priorities of the Saskatchewan Party with respect to the Community Clinics have not yet been fully revealed. This in itself causes uncertainty for the Clinics.

Additional ambiguity is caused by the government’s shifting criteria and standards by which the performance of the Clinics is judged. At times, it has appeared that the government has “cherry-picked” these criteria, creating

inconsistencies over time in how they have been held to account for the funding they receive.

The conflicting ideas and ideologies of the actors in the health policy domain serve to magnify the ambiguity in the relationship. Perhaps the most interesting source of ambiguity is that some leaders of the Community Clinics do not fully recognize that they have become increasingly marginalized. Some Clinic informants appear to cling to the hope that they can remain as they were originally conceived over 45 years ago.

7.6 Toward a New Understanding: The Community Clinics as Hybrid Organizations

This research contributes a richer and deeper understanding of the relationship between the Community Clinics and the provincial government that has previously been little studied. The key informant interviews in particular add depth as well as insights into the views of Clinic founders and supporters, the politicians, department officials, Health Region officials, and others involved in or affected by the relationship. Together with an examination of additional primary and secondary sources, analysis of the key informant interviews provides new explanations in answer to the research questions.

The Community Clinics appear to be unique types of hybrid organizations in many respects. They are not fully co-operatives, not fully public sector organizations, and not fully private sector entities. They are hybrids – anomalies that public policy has not yet been able to accommodate. When all of the different conceptualizations of the Clinics are considered, there is no doubt that the relationship between the Clinics and the government is ambiguous and problematic. Attribution of “blame” for

the state of the relationship cannot be assigned in simple fashion to only one party; the relationship is much more complex, layered and dynamic.

The streams of literature examined in this study are found to be incomplete in building a new understanding of the relationship between the Community Clinics and the provincial government. Only partial answers to the research questions can be found by applying the theory and concepts discussed. For instance, Hall's (1993) delineation of the conditions necessary for achieving policy change indicates that the accumulation of anomalies that existing policies cannot accommodate can result in a major shift in policy paradigms. However, the small number of anomalies that the Community Clinics present to the policy-making process may make it unlikely that a major shift would occur. The dominant ideologies concerning fee-for-service remuneration and the pre-eminent role of private medical practice remain firmly embedded within the medical establishment, although the provincial government has been trying to change this.

The relationship between the Community Clinics and the government does not reflect the admittedly somewhat ideal situation that Vaillancourt (2008) conceptualizes for social economy organizations with respect to public policy construction. Instead, the analysis shows that policy-making is not a collaborative process in which all stakeholders, including the Community Clinics, have access and participate as respected social actors. Government does not appear to treat all partners equally, whether from the private sector or the social economy. Government decision-makers do not appear to have established open, inclusive dialogue between themselves and the leaders of the Community Clinics, as Vaillancourt (2008) envisions. The Community Clinics appear to remain, at best, minor instruments of implementing public policy. They are co-producers, not co-constructors.

Stanbury (1993) notes that the outcomes of the relationship between business and the government are frequently ambiguous; the outcomes of the relationship between the Community Clinics and the government remain ambiguous in several respects. The government continues to fund the Community Clinics but there is no clear indication that it will continue to do so. There is no clear indicator of the government's policy toward the Community Clinics. The results from this study only suggest that the Community Clinics may serve a competitive yardstick role, that they may be an incubator of innovation and a laboratory for testing new programs and services, and that their connection to the birth of Medicare influences the government to continue supporting them.

There is also a suggestion in the literature on the role of ideas in public policy that existing policy is dependent, at least in part, on what has historically been the policy. There is, in short, a sort of creeping incrementalism. But lack of a clear public policy role indicates that government support for the Clinics can be categorized at best at level 2 in Hoyt's (1989) continuum – neutral with neither positive nor negative policies. The government continues to provide funding but does not actively support the co-operative Community Clinic model. It also places limits on their accessibility to Cabinet members and government MLAs. Support from the politicians seems to be more ceremonial and symbolic than substantive. There is, however, no ambiguity about where the balance of power resides – the government dominates the Clinics.

Many social economy organizations are dependent on governments for significant portions of their funding, but not many co-operatives are in the same situation. Some definitions of social economy enterprises separate those that earn most of their revenue from the market from nonprofit entities that are highly

dependent on government funding. The various definitions of the social economy that appear in the literature generally encompass all of these – social enterprises that earn revenue in the market, nonprofits dependent on government funding, and co-operatives, that can be both “for-profit” and nonprofit-oriented. The Community Clinics are a special case in the constellation of social economy organizations, and are unique among co-operatives in Saskatchewan.

Recent developments in primary health care suggest that if the Community Clinics reconceptualize themselves, their future may be more secure. At present, there is a “perfect storm” in the delivery of primary health care delivery in both the United States and in Canada. An unusual combination of circumstances in health care is manifesting itself such that the Community Clinics may finally be able to secure a place at the health care policy-making table. In Saskatchewan, the Ministry of Health announced an independent review in November 2008 to examine the health care system from the perspective of patients and their families (Government of Saskatchewan. News Release. November 5, 2008). The recommendations of the “Patient First Review”, if adopted by the government, would focus care on the needs of the patient, rather than the needs of the health care system, to address “timely access, health care innovation, efficiency and patient satisfaction” (Government of Saskatchewan. News Release. October 15, 2009). The Clinics have an opportunity to position themselves as having long provided patient-focused care as well as possessing a significant record of innovation in the delivery of primary health care.

In the United States, the recent passage of new legislation (Patient Protection and Affordable Care Act (PPACA; Pub. L. No. 111-148) that will expand provision of publicly-funded and -administered health care in a system similar to that of Medicare in Canada (The White House. Summary of Obama Plan) is causing considerable

controversy. It is not within the purview of this research to examine health reform in the United States, but much of the controversy centers around the perceived intrusion of the government into what private health care providers regard as their domain. At the core of the debate are questions about how the primary health care needs of people will be served and who may be left out.

A reconceptualization of the Community Clinics to take into account their ability to serve patients first, to provide the innovation this situation calls for, and to do so as publicly-funded entities may be the best avenue toward policy change. Advocacy for a reconceptualized Community Clinic model must be accompanied by a solid cost-benefit analysis and rhetoric freed from the mythology of the Clinics' past.

7.7 Directions for Future Research

This research has been exploratory in nature and establishes a path to further explore the concept of the Community Clinics as hybrids. Some of the implications for the Community Clinics for their autonomy and their ability to advance their advocacy agendas have been identified. Further research is required to more fully understand what being a hybrid that is not quite a co-operative, not quite a public agency, and not really a private sector enterprise means. Being a hybrid implies a degree of instability; additional research is necessary to identify the conditions under which hybrids would be sustainable, with specific reference to the policy environments that would enable sustainability.

As noted in Chapter Two, there are growing streams of literature on the third sector and public governance (for instance, Pestoff 2009; Brandsen and Pestoff 2008) and the emergence of hybrids in the social economy (for instance, Evers 2005; Graefe 2006). There is also scope for further research to compare the experiences of the

Community Clinics with those of the third sector and other hybrid social economy organizations, in Quebec, Europe and elsewhere, particularly those involved in primary health care delivery.

More specifically, however, there is considerable scope to examine governments' treatment of and public policy on co-operatives in Canada. The literature on how co-operatives fare with respect to their lobbying and advocacy efforts is quite dated (i.e., Fulton and Laycock 1990), and the literature on co-operative legislation in Canada is also quite old (i.e., Axworthy 1990). Research in these areas at both federal and provincial/territorial levels would address a large gap in the literature on co-operatives in Canada. What is the impact of lobbying by all types of co-operatives on legislation? What are the conditions necessary for effective influence on policy-making, especially those beyond having a sympathetic political party in power? A closer examination of the Clinics' own use of lobbying processes would also inform strategy formulation by other co-operatives and social economy organization.

With respect to the Community Clinics, an updated cost-benefit analysis that compares the Clinics' efficiency to that of private medical practice similar to that prepared by Angus and Manga in 1990 would be an important addition not only to the literature but also to the Clinics' lobbying and advocacy strategies.

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Appendix One – Co-operatives: Definition, Principles and Values

Co-operatives are voluntary associations organized and run on a democratic basis of one member, one vote in order to provide members with goods and services that they could not otherwise obtain. These goods and services may be made available to those who are not members but who may benefit from access to them, for instance, a community. Members participate economically (MacPherson 1996); that is, they contribute the capital on which co-operatives, at least initially, are run. Typically, this contribution of capital ensures that the members remain in control of their organizations. However, there are instances where co-operatives receive all or part of their operational funds from outside organizations. There have been few studies of how co-operatives manage and members maintain control under such circumstances.

When people in Saskatchewan think of what a co-operative is, they might think of the local grocery store, the gas bar, the credit union, the daycare they send their children to, or the Community Clinics. Co-operatives also exist elsewhere in Canada, North America and around the world, and there are many definitions of what a co-operative is. The International Co-operative Alliance (ICA) issued a statement on the co-operative identity following extensive consultation with co-operative organizations around the world. This document included the following definition:

A co-operative is an autonomous association of persons united voluntarily to meet their common economic, social, and cultural needs and aspirations through a jointly-owned and democratically-controlled enterprise (MacPherson 1996).

This is the definition used in this dissertation. It emphasizes that co-operatives are associations but they are also enterprises that provide the means to meet their members' economic, social and cultural goals. The economic and associational aspects of co-operatives are symbiotic; one does not exist without the other.

Co-operatives generally subscribe to a number of values that are also set out in the statement on co-operative identity:

Co-operatives are based on the values of self-help, self-responsibility, democracy, equality, equity, and solidarity. In the tradition of their founders, co-operative members believe in the ethical values of honesty, openness, social responsibility, and caring for others (MacPherson 1996).

Seven related principles have been developed by which co-operatives operate.

These are:

1st Principle: Voluntary and Open Membership

Co-operatives are voluntary organizations, open to all persons able to use their services and willing to accept the responsibilities of membership, without gender, social, racial, political, or religious discrimination.

2nd Principle: Democratic Member Control

Co-operatives are democratic organizations controlled by their members, who actively participate in setting their policies and making decisions. Men and women serving as elected representatives are accountable to the membership. In primary co-operatives members have equal voting rights (one member, one vote), and co-operatives at other levels are also organized in a democratic manner.

3rd Principle: Member Economic Participation

Members contribute equitably to, and democratically control, the capital of their co-operative. At least part of that capital is usually the common property of the co-operative. Members usually receive limited compensation, if any, on capital subscribed as a condition of membership. Members allocate surpluses for any or all of the following purposes: developing their co-operative, possibly by setting up reserves, part of which at least would be indivisible; benefiting members in proportion to their transactions with the co-operative; and supporting other activities approved by the membership.

4th Principle: Autonomy and Independence

Co-operatives are autonomous, self-help organizations controlled by their members. If they enter into agreements with other organizations, including governments, or raise capital from external sources, they do so on terms that ensure democratic control by their members and maintain their autonomy.

5th Principle: Education, Training and Information

Co-operatives provide education and training for their members, elected representatives, managers, and employees so they can contribute effectively to the development of their co-operatives. They inform the general public – particularly young people and opinion leaders – about the nature and benefits of co-operation.

6th Principle: Co-operation Among Co-operatives

Co-operatives serve their members most effectively and strengthen the co-operative movement by working together through local, national, regional and international structures.

7th Principle: Concern for Community

Co-operatives work for the sustainable development of their communities through policies approved by their members (MacPherson 1996).

The International Co-operative Alliance (ICA) estimates that over 800 million people are members of co-operatives and that over half the world's population uses the services of a co-operative — including one in three persons in Canada. Co-operatives operate in all sectors and are found on all continents, provide over 100 million jobs around the world, and constitute the largest number of voluntary, democratically-owned and -controlled organizations in the world (International Co-operative Alliance website).

In Canada, there were 5,714 non-financial co-operatives with over \$27.7 billion in revenues, over 5.9 million members, and \$17.7 billion in assets in 2005 (Co-operatives Secretariat 2008). Non-financial co-operatives in Canada employed close to 88,000 people, with over 77% being full-time. Financial co-operatives, including caisses populaires, credit unions, and insurance companies, constitute a large component of the co-operative sector in Canada. Credit unions and caisses populaires had over \$181.3 billion in assets; seven co-operative insurance companies had \$33.5 billion in assets and their policy holders held 11.9 million certificates and policies (Co-operatives Secretariat 2008).

Closer to home, Saskatchewan had 1,306 co-operatives and credit unions in 1998 (the latest year for which comprehensive data are available) with over \$10 billion in assets, close to \$7 billion in revenues, and over 15,000 employees, and close to a million active members (Herman and Fulton 2001). Again, they were active in

all sectors of the economy, including, for example, agriculture, finance, child care, health care, community halls and recreation, cable television, and the arts. They ranged in size from a town hall in the smallest of communities to the largest of Saskatchewan's businesses. Their economic and social impact on the province has been considerable (Hammond Ketilson et al. 1998).

Appendix Two – Brief History of Medicare and Medical Care in Saskatchewan

This appendix provides a brief overview of the history of medical care and Medicare in Saskatchewan to establish the historical, political and social context for the case study of the co-operative Community Clinics. In conducting this study, it became apparent that the past is still very much present in the minds of some of the key informants interviewed. Since much has been written about the Medicare crisis, this section concentrates on some key sign posts along the way to 1962.

Saskatchewan is not only the birthplace of Medicare but also of a number of other innovations in the organization and delivery of health care, some of which were subsequently adopted on a national basis (Houston 2002; Lawson and Theriault 1999). These innovations arose out of the need for practical solutions to the challenges of life at the end of the 19th and beginning of the 20th centuries, including a harsh climate, sparsely distributed population and limited access to medical care, which was primarily available in larger centres (Badgley and Wolfe 1967; Rands 1994; Lawson and Theriault 1999). Just as co-operatives form on the basis of self-help and mutual aid, so too did medical care solutions in Saskatchewan.

According to Houston (2002), when Saskatchewan became a province in 1905:

...there were six hospitals in operation, four of them with nursing schools. Their seventy-five beds served over 250,000 people. In the 1901 census, populations of the main towns were as follows: Regina 2, 249, Prince Albert 1,745, Moose Jaw 1,558, Moosomin 868, Yorkton 799, Battleford 609, and Maple Creek 382 (Houston 2002:12).

In response to the need for access to a doctor in rural locations, the Rural Municipality of Sarnia offered its doctor a retainer fee of \$1,500 annually (Creighton

1970 quoted in Rands 1994: 4; Badgley and Wolfe 1967)⁹. According to *The Rural Municipalities Act* passed in 1909, rural municipalities were responsible for the care of people within their boundaries who were unable to pay for medical care. The population of rural Saskatchewan was growing quickly due to the inducements offered by the federal government's national settlement plan which provided land to immigrants (Rands 1994). Rural doctors' income was dependent on the farm economy and therefore farmers' ability to pay for doctors' services. The municipal plan allowed rural residents to receive medical care and doctors to be paid even when times were tough on the farm. *The Rural Municipalities Hospitals Act* was amended in 1916 to allow municipalities to provide a grant to doctors to supplement their income providing the grant did not exceed \$1,500 (Rands 1994: 22).

In 1919 legislation was passed to allow municipalities to hire doctors on salary to provide free medical care to the municipalities' residents. This was followed in 1932 by permission for parts of municipalities to employ a doctor, or two or more municipalities to co-operate. In 1935, the Towns and Villages acts were changed to allow for per capita assessments to hire a doctor. Legislation passed in 1937 allowed \$5,000 to be raised to hire a surgeon. Finally in 1941, *The Rural Municipalities Act* was amended such that doctors could be paid on a fee-for-service basis from public funds (Rands 1994).

The municipal plan spread quickly across the province: "By the time the CCF came to power in Saskatchewan in 1944, the residents of 101 of the province's 303 rural municipalities, sixty villages and eleven towns with a combined population of 200,000 were receiving medical services from salaried municipal doctors" (Lipset 1950: 228). When the Dirty Thirties hit the province, the government established a

⁹ Lawson and Theriault 1999 say that the first municipal doctor plans was established in 1915, providing an annual salary of \$2,000.

medical relief plan so that drought-stricken municipalities could maintain medical services. However, many municipalities went without service (Rands 1994).

As well as being home to the first municipal doctor in North America (Houston 2002), Saskatchewan was responsible for several other important innovations in medical care:

Saskatchewan was the first jurisdiction in North America to introduce free diagnosis and treatment for tuberculosis (1929), universal hospital insurance (1946), universal medical insurance (1962), and universal prescription drug insurance (1974-1982) (Lawson and Theriault 1999: 251).

Early in the 20th century, Saskatchewan residents suffered from tuberculosis and there was a groundswell of grassroots action to tackle this disease. The Saskatchewan Anti-Tuberculosis League was founded in 1911 and began providing treatment in 1917 at sanatoriums that it built and operated with donations and grants from provincial and federal governments (Houston 1991). Although most patients had to pay part of the costs and the government provided a small per-diem, the treatment was costly and this bankrupted some patients and deterred others from seeking treatment. In 1929 the Liberal government passed legislation to cover the costs in full through grants and assessments on all of the province's municipalities (Lawson and Theriault 1999: 232).

Lawson and Theriault (1999) note that a similar service was demanded in the cities. The government passed *The Municipal Medical and Hospital Association Act* in 1938, permitting ten or more people to incorporate a health insurance plan for its members:

The first group of citizens to organize a medical service under the act, the Regina Mutual Medical Benefit Association headed by H. L. Fowler (manager of Consumers' Co-operative Refineries Limited), obtained applications from eight doctors to work in a co-operative clinic that was to be staffed by salaried physicians. Foreshadowing the

SCPS' reaction to those doctors who were willing to work for the CHSAs in the 1960s, the Regina District Medical Society successfully pressured all eight applicants to withdraw from the project. The cooperative organized a simple indemnity plan that provided coverage for their members' medical fees. Similar fee-for-service plans were organized in Saskatoon, Prince Albert and Melfort (Lawson and Theriault 1999: 255).

Badgley and Wolfe (1967) note that "By opposing the medical co-op in 1939, the Regina doctors reasserted their commitment to private enterprise and to the fee-for-service payment of their bills" (Badgley and Wolfe 1967: 17).

The Mutual Medical and Hospital Benefits Associations together with the Saskatchewan State Hospital and Medical League, a large number of trade unions, and agricultural organizations recommended to the Sigerist Commission that doctors be paid on a salary basis (Lawson and Theriault 1999). This was also the position of the Saskatchewan Federation of Agriculture which represented organized producer and consumer co-operatives. The Sigerist Commission (Report of the commissioner Henry E. Sigerist: presented to the Minister of Public Health, October 4, 1944) was established by Tommy Douglas as Premier and Minister of Public Health after the CCF came to power in 1944 following the defeat of a Liberal government (Badgley and Wolfe 1967). The purpose of the commission was to survey health services in Saskatchewan and make recommendations to the government regarding next steps (Tollefson 1963; Lawson and Theriault 1999; Rands 1994; Houston 2002). The commission's recommendations included:

- Establishment of a Health Services Planning Commission to implement health programs in the province.
- Establishment of health districts for preventative medicine, organized around a hospital with x-ray, laboratory and ambulance services.
- Establishment of a number of rural centres for maternity care.
- Maintenance and further development of the municipal doctor plan and annual vacation with pay for the overworked and underpaid municipal doctors

- Education of the public so that they went to the central services in their health region instead of having the municipal doctors travel to them.
- Free hospitalization for all residents of the province. This would require additional hospital beds, including the establishment of a hospital attached to the College of Medicine in Saskatoon.
- Remuneration of medical staff by salary (Report of the commissioner Henry E. Sigerist: Presented to the Minister of Public Health, October 4, 1944).

Under intense pressure from the College of Physicians and Surgeons, the CCF government subsequently rejected the plan devised by its own health planners that called for the expansion of the municipal doctor plan into “state-salaried medical service stationed in group practice clinics with some measure of lay control” (Lawson and Theriault 1999). In spite of this, popular demand for group practice clinics continued.

In 1946, the Saskatoon Mutual Medical and Hospital Benefits Association announced a plan to establish a group practice clinic with salaried doctors and satellites in neighbouring rural centres (Lawson and Theriault 1999). The Saskatoon District Medical Society then established Medical Services Insurance (MSI), a doctor-sponsored fee-for-service plan to compete with the co-operative and threaten its success. MSI grew substantially and successfully deterred the expansion of lay co-operatives and the municipal doctor plan. Another group called Group Medical Services was established in Regina (Lawson and Theriault 1999).

According to Tollefson (1963), the introduction of *The Saskatchewan Hospitalization Act* in 1946 was a key step along the road to achieving a comprehensive medical care plan for Saskatchewan. This was followed by the establishment of the first Health Region in the province with a prepaid plan of health insurance. This was the Swift Current Health Region (Rands 1994; Tollefson 1963;

Lawson and Theriault 1999; Badgley and Wolfe 1967; Feather 1991). This Region was, in fact, established by local residents, municipalities and medical personnel who were willing to experiment. The provincial government contributed to the costs, but these were largely covered by the residents themselves through a personal tax, as well as an assessment through the property taxes collected by the municipalities. Fee-for-service payment provided about 75% of the total costs and the plan covered dental, medical and hospital care. Although the Swift Current experiment was deemed a success, Tollefson (1963) notes that the provincial government did not pursue the establishment of other Health Regions until after the introduction of universal medical care coverage in 1962 (Tollefson 1963: 42).

The federal government began contributing to the hospital plan in 1958 (Badgley and Wolfe 1967). Tommy Douglas had previously said that he would not advance a comprehensive medical care program until the federal government started to pay a share of the existing costs (Johnson 2004). The province could not afford such a plan without federal contributions. In 1959 Tommy Douglas announced his plans to establish a provincial plan based on five principles:

- (1) Pre-payment principle
- (2) Universal coverage
- (3) High quality service
- (4) Administration by the Department of Public Health or an agency responsible to the Government
- (5) Acceptability to both those providing and those receiving the services (Tollefson 1963: 45).

By then, the number of municipal doctor plans had decreased substantially and the early medical co-operatives were also in decline (Lawson and Theriault 1999: 256). Douglas appointed an Advisory Planning Committee on Medical Care led by Dr. W.P. Thompson to “carry out investigations and make recommendations to the Government relating to a program of medical care” (Tollefson 1963: 53). The

committee was to have representatives of the government, the medical profession, the public and the College of Medicine. Draft terms of reference for the committee were proposed to the College of Physicians and Surgeons but it would not agree to the terms and refused to participate in the committee until quality of care was removed from the terms. The doctors objected to anyone outside the medical profession being involved in evaluating the quality of their services. The Douglas plan became an issue – if not *the* issue – in the provincial election of 1960, which the CCF won.

The work of the Thompson Committee was slow due to the medical profession's objections to the idea of publicly funded and administered medical care generally. Badgley and Wolfe (1967) note that the government did not adequately engage the medical profession to develop lines of communication, and:

Even more surprisingly, the provincial government had never separated the functions of the profession in licensing, setting standards, and self-discipline, from its trade-union or negotiating role in economic matters. Since all of these powers, in Saskatchewan, rested in the same body with the same paid official executing policy on all of these matters, the profession was in a much stronger position to control dissenters, particularly since the composition of the nine-man Council of the profession changed very slowly (Badgley and Wolfe 1967:29).

Ultimately, the Thompson Committee issued an interim report in September 1961, with a minority report from the College of Physicians and Surgeons (Tollefson 1963). The interim report recommended a comprehensive, universal plan to be publicly administered by the province, and recommended the establishment of an independent commission to administer the plan. The report also recommended fee-for-service remuneration for physicians, although some committee members did want alternate forms of payment such as salary or capitation¹⁰ (Tollefson 1963).

¹⁰ Capitation is a system where physicians are reimbursed on the basis of a set amount for each patient seen. It has been criticized for encouraging physicians to “cherry pick” healthy patients so as to boost the number they can see. Patients who are not in good health require more time and effort, thus limiting the number of patients that can be seen. See, for instance, Pearson, Sabin and Emanuel 1998.

The representatives of the College of Physicians and Surgeons along with the representative from the Chamber of Commerce issued a minority report in disagreement with the committee's interim report. The College disagreed with the need for a mandatory universal plan administered by a single insurer – the government. The doctors wanted to continue to operate their own insurance plans under Group Medical Insurance and Medical Services Insurance, arguing that residents should be able to obtain their care privately (Tollefson 1963).

Nonetheless, the Premier pushed ahead with the legislation required to implement the recommendations of the majority report. It was introduced on October 25, 1961 and enacted on November 17 (Tollefson 1963; Badgley and Wolfe 1967). The Medical Care Insurance Commission was established on January 9, 1962 (Tollefson 1963; Rands 1994). The College then refused to participate in the commission because the government had promised to give it an opportunity to review the bill and make its recommendations regarding any changes before it was introduced into the Legislature. Badgley and Wolfe (1967) state that:

There is little doubt that the Minister of Public Health, Mr. Erb, and his senior advisors acted unwisely in not making the draft legislation available to the profession earlier than they did. The annual meeting of the profession was in progress at the time the legislation was being enacted in mid October 1961, and no one who was present could have failed to sense the wave of anxiety that pervaded the assembly (Badgley and Wolfe 1967: 40).

Physicians felt that their freedom to practice would be restricted and that the plan would lead to them becoming salaried employees of the state, which was to be avoided at all costs. Implementation of the plan was to take place on April 1, 1962 but was delayed to July 1, 1962 because of the time needed to set it up (Rands 1944).

In the meantime, the doctors gained political support from the Liberal government and the public and threatened to strike if the government did not concede

to their demands (Johnson 2004; Badgley and Wolfe 1967). The government began to recruit doctors to provide medical services if a strike occurred. Although the government and the doctors tried to negotiate an agreement, this was not possible. The doctors withdrew their services on July 1. Emergency services were provided at 29 hospitals across the province.

The strike lasted 23 days (Rands 1994; Johnson 2004; Tollefson 1963; Lawson and Theriault 1999). This was a time of complete upheaval in the province. Keep Our Doctors groups were organized across the province by citizens who feared losing their local doctors and access to medical services (Johnson 2004; Tollefson 1963; Badgley and Wolfe 1967). Government ministers and officials were harassed and threatened. The doctors brought in to replace striking ones were also treated this way. In some cases, they could not obtain hospital privileges or licenses to practice (Lawson and Theriault 1999; Rands 1994; Tollefson 1963). The newspapers in the province sided with the Liberals and the doctors on strike; the out-of-province press criticized the doctors (Johnson 2004; Press coverage of Medicare, Presentation of Hon. A. E. Blakeney February 19, 1963 to Canadian Managing Editors' Conference; Badgley and Wolfe 1967).

The government in the meantime tried to continue negotiations with the College of Physicians and Surgeons. Some progress was being made because public opinion started to shift away from the doctors and not all of the doctors were behind the College in its fight with the province. They gradually started going back to work.

The Premier had asked Lord Stephen Taylor from Britain to come to the province to advise the government; however, when he arrived, he assumed the role of mediator in the strike (Johnson 2004; Badgley and Wolfe 1967). He was a well-known physician in Britain and had been involved in setting up its National Health

Service. Because he was a doctor, he was able to meet with both parties to the dispute and he drafted an agreement that both were able to sign. He arrived on July 16 and the strike ended on July 23, 1962 with the signing of the Saskatoon Agreement (Johnson 2004; Tollefson 1963; Rands 1994).

The act which enabled the first medical co-operatives to be established still existed and when the doctors went on strike, some 38 communities began to organize or set up Community Clinics to provide medical services (Tollefson 1963; Rands 1994; Lawson and Theriault 1999; Badgley and Wolfe 1967). Many disbanded when the Saskatoon Agreement was signed. Others carried on with a strong belief in member ownership and control over their health care, working in partnership with doctors who also believe in lay participation. Three remain in the province.

Appendix Three – Letter Seeking Permission to Interview

October, 2005

Dear:

RE: Permission to Interview Officials

I am a PhD candidate at the Centre for the Study of Co-operatives at the University of Saskatchewan. I am studying the relationship between the co-operative community health clinics and the provincial government, focusing on the period since the Wellness approach and Health Reform became priorities of the New Democratic Party following its return to power in the election of 1991. My supervisor is Dr, Lou Hammond Ketilson, Director of the Centre for the Study of Co-operatives.

As part of my work, I plan to interview key people involved in health care provision in the province, including elected and appointed officials. The interviews, which would be audio-taped with the participants' permission and last approximately one hour, will involve questions about the role that the clinics should play in the delivery of primary care in Saskatchewan. The interviews will be transcribed and copies forwarded to participants to ensure that the transcriptions accurately capture their views and responses.

Every possible measure will be taken to ensure that the identity of the participants is kept confidential. This research will form part of my dissertation entitled: "The Relationship between Saskatchewan's Community Health Care Clinics and the Government of Saskatchewan: Toward a New Understanding" and may subsequently be published in scholarly journals and other venues.

I therefore request permission to interview you and the senior administrator (or designate) in your organization. I will call your office in approximately one week to arrange a time at your convenience. If you have any questions, I can be reached at (306) 966-6660.

I hope you will agree to participate in this research.

Thank you for your attention to this matter.

Sincerely,

Rochelle Smith

Appendix Four: Semi-Structured Interview Guide for Clinic Participants

The following questions identify the main areas that the researcher intends to explore through the personal interviews. The questions are intended to guide the participants and garner their thoughtful responses. It is expected that in some cases, depending on the nature of the response, the discussion might go outside the expected scope of the interview. The respondents will be allowed and encouraged to tell the stories they think are the most important.

Questions for Discussion with Interview Participants:

This research is looking at the relationship between the community health clinic co-operatives and the provincial government since the return of the New Democratic Party (NDP) to power in 1991 and up to the present. Health reform became and has remained a major initiative of the government, with expenditures on health care constituting the largest portion of its expenditures.

1. What role do you think the community health clinic co-operatives play in the provision of health care services in the province?
2. What services do the clinics provide?
3. What are the advantages of delivering health care services using the co-operative model?
4. Disadvantages?

5. What challenges and/or opportunities do the clinics face in their operations?
6. What formal relationships have been created with institutions, agencies and professionals in the community?
7. What informal relationships have been established with facilities and professionals in the community?
8. How well has the co-operative model worked in promoting government health policy objectives, i.e., in terms of such things as providing integration/continuum of health care services, community-based services, promotion/prevention?
9. How would you describe the relationship of the community health clinic co-operatives with the provincial government? With the Regional Health Authority? With the medical profession?
10. What aspects of the relationship are positive? Negative?
11. Have these relationships changed over time and how?
12. Is there a difference between how government officials regard the clinics and how the elected members of the government regard them? What is that difference?

13. What needs do the community clinics have which are not currently being met by government? How could they be met?
14. Does the political cycle of the provincial government (elections every four years or so) affect the clinics, and, if so, how?
15. How successful have the clinics' lobbying efforts been?
16. There have been numerous royal and other commissions into health care reform, both in Saskatchewan and at a national level. Perhaps the most important in Saskatchewan's case are the Fyke Commission and the Romanow Commission. Did these commissions address the co-op health care clinic model? Did the co-op model receive adequate attention in either commission's report?
17. Where do you think the clinics will be in five years? Ten?
18. Are there any significant trends in the delivery of health care that may impact on the clinics in the future?

Appendix Five–Semi-Structured Interview Guide for Non-Clinic Participants

The following questions identify the main areas that the researcher intends to explore through the personal interviews. The questions are intended to guide the participants and garner their thoughtful responses. It is expected that in some cases, depending on the nature of the response, the discussion might go outside the expected scope of the interview. The respondents will be allowed and encouraged to tell the stories they think are the most important.

Questions for Discussion with Interview Participants:

This research is looking at the relationship between the community health clinic co-operatives and the provincial government since the return of the New Democratic Party (NDP) to power in 1991 and up to the present. Health reform became and has remained a major initiative of the government, with expenditures on health care constituting the largest portion of its expenditures.

1. Do you think the community health clinic co-operatives have a role to play in the provision of health care services in the province?
2. If so, what should that role be?
3. If not, why not?
4. What, if any, formal relationships does your organization have with the clinics?

5. What informal relationships have been established in the community, e.g. regarding professionals or facilities?
6. What aspects of the relationships are positive? Negative?
7. Are there advantages to the co-operative clinic model? Disadvantages?
8. A number of studies have been done that indicate that the clinics are more cost-effective than private practices in the delivery of health care services. For instance, the Angus and Manga report of 1990 found that the clinics' overall costs per patient were lower. Clinic patients had shorter hospital stays and lower prescription drug costs. Given these findings, do you think that the co-operative clinic model should given more profile in the provincial government's efforts to contain costs?
9. Do you think that there is any difference in the quality of health services delivered between the co-op community clinics and private practices?
10. The Saskatchewan provincial and government governments have just announced a national campaign to raise awareness of primary health care, focusing on four pillars, including:
 - Health care providers working in teams,
 - Improved sharing of information among health care providers and patients,
 - Better access to health information, and
 - Healthy living.

11. The co-operative community clinics have been actively pursuing these pillars since their inception. Do you think that the governments should incorporate the co-op clinic model into this national campaign?

12. Saskatchewan is traditionally viewed as a stronghold of the co-operative movement and as an innovator in health care delivery and reform, yet the co-op delivery model for health care does not seem to have grown and developed to the extent that it could. Are there barriers to this growth and development? If so, should they be removed?

13. What are your organization's plans for primary health care services? Where do you hope they will be in five years? Ten?

Appendix Six – Interview Consent Form

Interview Consent Form

You are invited to participate in a study called: *The Relationship between Saskatchewan's Co-operative Community Health Care Clinics and the Government of Saskatchewan: Toward a New Understanding*

Researcher: _____ Rochelle Smith _____ (name)
_____ Centre for the Study of Co-operatives _____ (address)
_____ University of Saskatchewan _____
_____ 101 Diefenbaker Place _____
_____ Saskatoon SK S7N 5B8 _____
_____ (306)966-6660 _____ (phone)

Purpose and procedure: I would like to receive your responses to some questions about the relationship between the community health clinic co-operatives and the provincial government in Saskatchewan. You have been selected because (of your position as a clinic administrator/as a chairperson of a clinic board of directors/as an official of the provincial government who deals with clinic funding/as an expert in the health care industry/as an elected official of the Government of Saskatchewan/as a representative of a health organization in Saskatchewan). This research project is co-ordinated by the Centre for the Study of Co-operatives at the University of Saskatchewan. The results of this research will constitute Ms. Rochelle Smith's dissertation requirement for a PhD in Interdisciplinary Studies, Co-operative Theme. The research is partially funded by the Centre for the Study of Co-operatives.

The purpose of this dissertation is to explore the relationship between the three co-operative health care organizations in Prince Albert, Regina and Saskatoon, Saskatchewan and the Government of Saskatchewan. How have these relationships evolved over time and how have the clinics survived changing legislative, regulatory and policy environments? What factors have influenced the provincial government's position on the co-operative community clinic model? Is there a difference in how the elected government officials and how the bureaucrats view the co-operative community clinic model? These are the questions this research aims to examine.

Your participation in this study is appreciated and completely voluntary. It is expected that the interview should last approximately one hour. You may withdraw at any time without penalty during this process should you feel uncomfortable or at risk. All interviews will be audio taped if you agree, and you have the right to shut off the recorder at any time you choose. You should also feel free to decline to answer any particular question(s). Should you choose to withdraw from the study, no data pertaining to your participation will be retained.

Potential risks: You should be aware that controversial remarks may have negative consequences for your relationships with others involved in community health care co-operatives in Saskatchewan. If Ms. Smith wishes to quote you, she will seek your permission beforehand.

Potential benefits: Your participation will help document the nature of the relationship between the community clinics and the provincial government. Findings from this research may help to inform policy decisions made within the co-operative sector and the provincial government.

Storage of data: The transcripts and original audio recording of the interview will be securely stored by the Supervisor (Dr. Hammond Ketilson) at the Centre for the Study of Co-operatives for a period of at least five years.

Confidentiality: Because of the relatively small number of people involved in administering and overseeing the co-operative health clinics in the province, and the need to identify and describe the nature of the relationship between the provincial government and the clinics, there are challenges around keeping the identities and opinions of the participants confidential. You are therefore asked to participate with the understanding that your views may be made public through the various modes of dissemination described below. If you choose not to participate, your wishes will be respected.

The research conclusions will be published in a variety of formats, both print and electronic. These materials may be further used for purposes of conference presentations, or publication in academic journals, books or popular press.

Your de-identified data may be used by other researchers in the future. You have the right to refuse to allow your data to be used by other researchers in the future.

Right to Withdraw: You may withdraw from the study for any reason, at any time, without penalty of any sort. If you choose to withdraw from the study, any information that you have contributed will be deleted. You will be informed of any major changes that occur in the circumstances of this study or in the purpose and design of the research that may have a bearing on your decision to remain as a participant.

Questions: If you have any questions concerning the study, please feel free to contact the Researcher at the number provided above.

This study was approved on ethical grounds by the University of Saskatchewan Behavioural Sciences Research Ethics Board on October 28, 2005. Any questions regarding your rights as a participant may be addressed to that committee through the Office of Research Services (966-2084). Participants from outside Saskatoon may call the Ethics Office collect.

Consent to Participate: 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,

understanding that I may withdraw this consent at any time. A copy of this consent form has been given to me for my records.

(Signature of Participant)

(Date)

(Signature of Researcher)

(Date)

Use of data by future researchers: I understand that my de-identified data may be used by future researchers.

I agree that my de-identified data may be used by future researchers.

I refuse to allow my de-identified data to be used by future researchers.

(Signature of Participant)

(Date)

(Signature of Researcher)

(Date)

Appendix Seven:

Division of Powers between Federal and Provincial Governments

Co-operatives' attempts to influence government policy are led by the Canadian Co-operative Association (CCA), the apex organization representing English-speaking co-operative organizations in Canada¹¹. The CCA may be seen as having limited clout because of the diversity of its members. Where governments normally prefer to deal with specific sectors and their associations (for instance, the Canadian Manufacturing Association), CCA represents co-operatives operating in all sectors of the economy. Further, government officials do not normally think of co-operatives when designing policies and programs, let alone think of them as being affected differently than private firms. This also has the effect of reducing CCA's profile (Fulton and Laycock 1990: 150).

Fulton and Laycock further note that, contrary to what might reasonably be expected, co-operatives do not benefit from any special legitimacy that might be accorded them because of the affinity of their democratic structures to those of government. Governments need quick decisions on public policy, and group participation in policy communities "requires a level of political autonomy for the business association which is simply incompatible with the democratic character of a third-tier co-operative organization" (Fulton and Laycock 1990: 151).

The first challenge arises because of the division of powers between the federal and provincial governments. Canada's constitution divides the powers of the state into federal and provincial/territorial responsibilities (*Constitution Act 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11). The federal government, for instance, is responsible for matters affecting the whole country such

¹¹ French-speaking co-operatives are represented by le Conseil Canadien de la Coopération.

as national defense, international trade and immigration. The provinces/territories are responsible, for instance, for municipal government, education and health care.

Every level of government has numerous levels of regulatory agencies, boards and commissions, resulting in greatly increased work for co-operatives to effectively bring their concerns to the attention of those in power. With respect to co-operative legislation, the federal government has responsibility for regulation of a small number of co-operatives that do business mostly on an interprovincial basis (*Canadian Cooperatives Act*, S.C. 1998, C-1.7). At the federal level, the agency responsible for addressing co-operative matters is the Co-operatives Secretariat, located in the Department of Agriculture and Agri-Food Canada. Although it does not have a statement of what the federal government's policy on co-operatives is, the Secretariat's mission and mandate are to:

Our Mission

The Co-operatives Secretariat is dedicated to economic growth and social development of Canadian society through co-operative enterprise.

Our Mandate

Ensure that the needs of the co-operative sector are taken into account by the federal government, especially in the development of policies and programs.

Inform the federal government's key players about the role and the potential of co-operatives in the development of Canadian society and its economy.

Foster a beneficial exchange of views among the federal, provincial and territorial governments, co-operatives, academics and other stakeholders engaged in the development of co-operatives.

Facilitate interaction between co-operatives and the federal government.

Provide governments, key economic stakeholders and the general public with information that promotes an accurate understanding of co-operatives and the co-operative model of enterprise (http://www.agr.gc.ca/rsc-src/coop/index_e.php?s1=info&page=intro).

The federal Co-operatives Secretariat was established in response to the 1984 National Task Force on Co-operative Development (Co-operative Union of Canada 1984) which requested a small supporting agency within the federal government to address their needs. Fulton and Laycock note that: “The proposal for a secretariat has since then become one of Canadian co-operative leaders’ clearest expressions of intent to establish closer and formal ties to the state” (Fulton and Laycock 1990: 152). This they see as a major departure from the usual position of anti-statist neutrality assumed by co-operatives and as posing a danger to maintaining the “democratic character of inter-co-operative and intra-co-operative activity.” Establishment of the secretariat is viewed by Fulton and Laycock as translating into less autonomy for co-operatives, and a somewhat ironic move:

...co-operatives are asking the Canadian state to play the principal role in assisting co-operatives to provide an alternative to what the task force describes as the unresponsive, bureaucratic institutions of the state. The state is to help co-operatives save Canadians from the state (Fulton and Laycock 1990: 153).

In the case of the secretariat, it is doubtful that its existence has resulted in less autonomy for co-operatives. The secretariat itself must struggle to gain the attention of other departments and agencies with respect to co-operative issues and concerns, and since its establishment, it has not developed a policy statement to set out how the federal government intends to support and work with co-operatives.

The Co-operatives Secretariat tries to bring the co-operative model and co-operative sector issues and concerns to the attention of officials in other federal government departments. Perhaps the most important initiative that the Co-operatives Secretariat has undertaken over the past few years is the Co-operative Development

Initiative, through which the federal government provides support for co-operative development.¹²

Provincial Jurisdiction

The provinces are responsible for legislation for incorporation of co-operatives, which has been quite uniform across the provinces since World War II (Fulton and Laycock 1990). Its purpose is the same as that for private sector firms – to provide a legal environment within which this form of enterprise may achieve its socially legitimate objectives. Co-operative Community Clinics in Saskatchewan have two options for incorporating. *The Mutual Medical and Hospital Benefits Association Act*¹³ was passed in 1938, permitting ten or more people to incorporate a health insurance plan for its members; it was this act that later allowed the establishment of the Community Clinics during the Medicare crisis. They can also incorporate under *The Co-operatives Act 1996*. Incorporation is done through the Department of Justice's Corporations Branch.

Axworthy (1990) discusses the constraints that co-operative legislation places on co-operative organizations with respect to their prescribed structure, powers of control and decision-making, and member participation. It is argued that what he speaks to is the theoretical underpinnings and systemic constraints in legislation that lead to principal-agent problems in co-operatives. Provincial governments differ in their treatment of co-operatives on the basis of the number and economic force of co-operatives of different regions, and on the basis of the strength of co-operatives in the

¹² The initiative has two components: one which provides funding to support projects that explore innovative uses of the co-operative model; the other which provides technical assistance to groups that want to start a co-operative or require assistance in managing existing ones. The latter is managed jointly with the Canadian Co-operative Association and le Conseil Canadien de la Coopération.

¹³ The Department of Health plans to repeal this act in the near future. There is only one community clinic incorporated under the act and it is in the process of securing a continuance under The Co-operatives Act 1996. Possible implications of this change are discussed in the next chapter.

provincial economy. The entity within government to address co-operative (and credit union) issues and concerns thus also varies. Responsibility for the incorporation of co-operatives and credit unions is usually separated from the entity that handles co-operative policy, program and development¹⁴.

¹⁴In some provinces/territories, it appears that there is no entity dealing with co-operative policy, programs and development at all. This is quite difficult to determine from information available on the provinces' and territories' web sites. Co-operatives are required by law to incorporate as legal entities so there is at a minimum an incorporation and registry function. In British Columbia and Alberta, for instance, there is only the registry and incorporation function. In Manitoba, a Cooperative Development Services unit exists within the Department of Agriculture, Food and Rural Initiatives under the Community, Cooperative and Regional Development Initiatives Branch, and the Registrar of Cooperatives is in the Finance department. The Cooperative Development Services unit also performs policy and program development functions.

In Ontario, the Financial Services Commission of Ontario handles incorporation. In Quebec, there is a dedicated unit within the department of Developpement Economique, Innovation et Exportation. Nova Scotia has a Co-operatives Branch in Service Nova Scotia and Municipal Relations Department; the branch combines the incorporation and registry functions with startup assistance, advisory services, inspections and winding-up services. In Prince Edward Island, there is an Inspector of Co-operatives in the Consumer, Corporate and Insurance Services Division of the Office of the Attorney General. In Newfoundland, the Corporate Registry is in the Commercial Registrations Division of the Department of Government Services. In the North West Territories, the Department of Justice has a Corporate Registries with a Registrar of Co-operatives, with some support on how to incorporate from a program officer at the Department of Industry, Tourism and Investment. In the Yukon, incorporation is done through Corporate Affairs, Consumer and Safety Services, Department of Community Services but there is no formal legislation, policy or organizational support for co-operatives. In Nunavut, the legislation and policy framework is being borrowed from the North West Territories but there are plans to develop its own in the near future.

Appendix Eight: Principles of Medicare, Canada Health Act

According to the federal Canada Health Act, the principles of Medicare are:

Public Administration: This criterion applies to the health insurance plans of the provinces and territories. The health care insurance plans are to be administered and operated on a non-profit basis by a public authority, responsible to the provincial/territorial governments and subject to audits of their accounts and financial transactions.

Comprehensiveness: The health insurance plans of the provinces and territories must insure all insured health services (hospital, physician, surgical-dental) and, where permitted, services rendered by other health care practitioners.

Universality: One hundred percent of the insured residents of a province or territory must be entitled to the insured health services provided by the plans on uniform terms and conditions. Provinces and territories generally require that residents register with the plans to establish entitlement.

Portability: Residents moving from one province or territory to another must continue to be covered for insured health care services by the "home" province during any minimum waiting period, not to exceed three months, imposed by the new province of residence. After the waiting period, the new province or territory of residence assumes health care coverage.

Residents temporarily absent from their home provinces or territories, or from the country, must also continue to be covered for insured health care services. This allows individuals to travel or be absent, within prescribed limits, from their home provinces or territories but still retain their health insurance coverage.

The portability criterion does not entitle a person to seek services in another province, territory or country, but is more intended to entitle one to receive necessary services in relation to an urgent or emergent need when absent on a temporary basis, such as on business or vacation.

If insured persons are temporarily absent in another province or territory, insured services are to be paid at the host province's rate. If insured persons are temporarily out of the country, insured services are to be paid at the home province's rate.

In some cases, coverage may be extended for elective (non-emergency) service in another province or territory, or out of the country. Prior approval by one's health insurance plan may also be required.

Accessibility: The health insurance plans of the provinces and territories must provide:

- reasonable access to insured health care services on uniform terms and conditions, unprecluded, unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means (age, health status or financial circumstances);
- reasonable access in terms of physical availability of medically necessary services has been interpreted under the *Canada Health Act* using the "where and as available" rule. Thus, residents of a province or territory are entitled to have access to insured health care services at the setting "where" the services are provided and "as" the services are available in that setting;
- reasonable compensation to physicians and dentists for all the insured health care services they provide; and
- payment to hospitals to cover the cost of insured health care services (*Canada Health Act, 1984, c.6.*).

Appendix Nine: Agreement Between Community Clinic A and Regional Health Authority

The agreement is as follows, with the name and location omitted to maintain confidentiality:

The Community Clinic
and
Regional Health Authority
(operating as the Health Region)

Principles of Partnership

The Community Clinic and the Health Region share a similar vision for supporting and enhancing health in the Health Region. For both, a closer, more defined, interdependent relationship is beneficial. This collaboration will directly benefit both organizations by promoting changes in the delivery of services that will enhance health in the communities mutually served.

Advocating on behalf of the client is a mutual goal of the organizations. This advocacy role can be strengthened by both organizations cultivating an interdependent relationship. This will have a positive impact on the determinants of health and ultimately improve the quality of health of the community.

The following principles are a partnership framework meant to be built upon and embraced as the partnership becomes more defined:

- The Community Clinic, the Health Region and other care providers are interdependent and need to operate collaboratively while demonstrating respect for each other's independence.
- Building and maintaining alliances serves the community well. Building pride and celebrating unique attributions contributes to the community and its health and well-being.
- Each organization will endeavor to provide information and input into future plans.
- Each organization will strive for clarity of its mandate and communicate these to each other and the community at large.
- Each health agency has respective policies and decision-making processes that will be respected and communicated appropriately.

- Consultation among health providers will be encouraged and facilitated in the best interests of the shared clientele.
- Each Board will provide for ongoing communication at the Board level and encourage open, two-way communication amongst all health providers and the community that is jointly served.

Goals of Partnership

Between:

Regional Health Authority,
(operating as the Health Region)

-and-

The Community Clinic

- 1.0 The Community Clinic and the Regional Health Authority will work in partnership to efficiently, economically and effectively provide high quality primary health services to the population we jointly serve.**

Objectives:

- a) **Work in partnership to identify and address primary health care needs in the health region.**
- b) **Work in partnership to prevent and manage chronic diseases in the health region.**
- c) **Work together to identify and address the health support needs of populations with poor health outcomes.**
- d) **Make effective, efficient and economic use of our health care resources.**

2.0 Maintaining and Strengthening our Partnership:

Objectives:

- a) **Representatives of the clinic and HR will meet regularly to review the Principles, Goals, Objectives and Action Plans of the Partnership to ensure that there is an ongoing progress to achieve positive outcomes for the health of the community.**

The clinic and the Regional Health Authority will maintain communication about the primary health planning processes (Clinic A unpublished document).

Appendix Ten: Search Results Using Weft Software

Endogenous Characteristics of Community Clinics

Search Terms	Clinics	Politicians	Govt Officials	Health Regions	Others
'autonomy'	3	1	0	1	0
'governance'	4	3	1	3	1
'board of directors'	1	1	1	1	0
'boards'	3	4	2	2	1
'community based'	0	1	0	0	0
'community-based'	2	1	0	1	0
'interdisciplinary'	2	1	1	1	0
'multidisciplinary'	2	0	0	1	0
'primary health care'	4	3	2	3	1
'model'	6	4	2	3	1
'democra'	4	3	1	2	0
'own'	6	4	2	3	1
Total	37	26	12	21	5

Exogenous Characteristics of Community Clinics

Search Terms	Clinics	Politicians	Govt Officials	Health Regions	Others
'perception'	2	3	0	1	1
'perceive'	2	2	0	0	1
'anomaly'	1	1	0	0	0
'belief'	0	2	0	0	0
'believe'	4	4	1	2	1
'centralize'	0	0	0	2	0
'centralization'	0	1	0	1	0
'centralizing'	1	0	0	0	0
'region'	5	4	2	3	1
'integrate'	1	0	0	3	1
'integration'	2	1	1	0	0
'efficiency'	0	2	2	2	0
'efficient'	4	3	1	2	1
'account'	5	2	0	2	1
'co-ordinate'	0	0	0	0	1
'old'	3	3	2	2	0
'young'	3	3	1	2	0
'past'	4	1	1	2	0
'present'	3	3	0	2	1
'current'	6	3	1	2	1
'belong'	2	0	0	2	1
'depend'	3	3	1	0	1
'power'	3	2	1	1	1
'control'	4	4	0	2	1
'fund'	5	3	2	3	1
'mandate'	1	0	1	1	0
'decision-making'	1	0	0	2	0
Totals	65	48	17	39	15

Government Intervention

Search Terms	Clinics	Politicians	Govt Officials	Health Regions	Others
'access'	4	2	2	2	1
'Saskatoon Agreement'	2	2	0	0	0
'law'	0	3	2	0	0
'legislation'	0	0	2	1	0
'MLA'	4	2	0	0	0
'Minister'	5	4	1	0	1
'ministers'	3	2	0	0	0
'cabinet'	2	3	0	0	0
'official'	4	1	2	1	0
'bureaucrat'	5	4	1	0	1
'bureaucracy'	5	1	1	1	0
'participa'	1	3	1	1	1
'power'	3	2	1	1	1
'control'	4	4	0	2	1
'controlling'	1	1	0	0	1
'controlled'	2	0	0	0	1
'Saskatchewan Medical Association'	2	0	1	1	0
'SMA'	5	4	2	3	0
'physician'	4	3	2	2	1
'doctor'	6	4	1	3	1
'medical profession'	3	4	1	0	0
'information'	3	1	2	3	1
'policy'	4	3	2	3	1
'public policy'	0	1	1	0	0
'policy process'	0	1	0	0	0
'new democratic party'	0	1	0	0	0
'ndp'	4	2	1	1	1
'liberal'	1	2	1	0	0
Totals	79	60	27	25	13

Influence Processes

Search Term	Clinics	Politicians	Govt Officials	Health Regions	Others
'advoca'	3	1	0	1	1
'lobb'	2	3	0	0	0
'participa'	1	3	1	1	1
'interest group'	1	1	0	0	0
'Saskatchewan Medical Association'	2	0	1	1	0
'SMA'	5	4	2	3	0
'physician'	4	3	2	2	1
'doctor'	6	4	1	3	1
'medical profession'	3	4	1	0	0
'federation'	6	1	0	1	1
Total	33	24	8	12	5