HEALTH CARE REFORM IN BRITISH COLUMBIA: DYNAMICS WITHOUT CHANGE?

by

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Abstract

The case study examines impacts on the exercise of power and the allocation of resources in health care delivery in British Columbia stemming from provincial policies of regionalization and devolution. The study examines the policy implementation process from 1993 to 1999, with the emphasis falling on the policy controversy provoked by the New Directions reform (1993 to 1996). The study also contributes to theory development regarding the policy implementation process by expounding and applying an approach to policy-as-ideology. Another subsidiary purpose is to contribute to theory regarding the power and accountability of health care providers and lay members of health services' governance structures. The study demonstrates the persistence of structural power relations within the health care sector. It concludes that the health reform initiative failed to impose controls over health care professionals and providers, failed to improve accountability of programmes to the public, failed to affect a reallocation of resources in the health sector, and failed to shift the policy perspective from the delivery of health care services to a community health perspective. The reorganization that was achieved through the reform did, however, strengthen administrative arrangements and improve technical efficiency.
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Preface

As Rudolf Klein dryly noted "health care reform was one of the international epidemics of the 1990's" (Klein, 1995a; p. 223). Regionalization was one symptom of that epidemic. Or, to change metaphors, advanced capitalist states bowed everywhere to "shifting ideological winds which favour the principle of higher levels of government being less directly involved in the activities of helping and caring . . . in favour of community-level agencies and local-level government" (Hall and Reid, 1998; p. 2).

The epidemic was caused by macro factors that are beyond the scope of the B.C. health reform case study. Those factors include globalization, the proliferation of information technology, and a general reshaping of international capitalism. The subject of the case study, however, is the local health policy response. How and why did the government of the province of British Columbia, qua state, respond to local exigencies given that backdrop of macro forces?

There are at least seven different ways of telling the story of how the B.C. government set a policy course of devolution and regionalization. ¹ First, there is the Cleopatra's nose version. The health reform policy, in this view, is essentially an accident of history, attributable to the naivete of the newly elected government and the enthusiasm of an energetic, but inexperienced and idealistic, minister. Second, there is the economic determinism version. The new government faced in 1991 an unanticipated deficit of over $2 billion and pessimistic health spending estimates. Third, there is a political version. Future electoral success by the governing New Democratic Party turned on reining in health care costs and implementing progressive health and social policies. Fourth, there is a policy learning version. By 1993, every Canadian province except Ontario had embraced a form of regionalization. Previous attempts to manage the health sector through conventional governing instruments of incentives and regulations had proved everywhere unsuccessful. Within B.C., the Victoria Health project demonstrated promise for improved results through service integration. By 1993, the B.C. government had experienced some success in overcoming the resistance of entrenched interests through community development strategies in the forestry and environmental sectors, leading it to favour such approaches elsewhere. Fifth, there is a policy soup version. By 1993, the government could draw on the experience of other provinces, its own experience in unrelated policy sectors, the ideas of the Seaton Commission, and the recommendations its own internal group had formed in response to that Commission. Sixth, there is the ideological outing version. By 1993, the government felt confident enough to show some of its ideological colours in the form of left-populism and citizen participation. Finally, there is an organizational predestination version. The complexity of large scale public sector programming, the growing capacity of information management technology, and the inherent dynamics of health care organizations work to force both decentralization to

¹ Rudolf Klein (Klein, 1995a; p. 196) styled six health policy stories to be "Cleopatra's nose", "economic determinism", "ideological outing", "policy learning", "policy soup", and "organizational predestination". To those, a seventh, a "political version" has been added by this study.
geographically defined regions and a centralization within those regions irrespective of government's health policy.

The case study shows all of these versions are plausible, but each is incomplete. They are complementary; each helps us "to understand different aspects of the policy making process" (Klein, 1995a; p. 176). Jointly, the factors worked to produce New Directions for a Healthy British Columbia, a policy that was remarkable in its attempt to connect goals of cost-control with reduction of health care provider influence with community participation and a broader conception of health.

New Directions contained no new themes. Like regionalization, the strategy of reducing provider influence loomed large in health reforms elsewhere – notably Mrs. Thatcher's attempt to reform the National Health Service. Like regionalization, the rhetoric (and to some degree, policies and programmes) relating to healthy communities, healthy schools, and healthy environments were not new. Versions of a broader concept of health had currency in Canada since 1974. The novelty of New Directions lay in connecting the themes into a coherent ideology grounded in a vision of citizens taking control over, and responsibility for, their individual and collective health, including the programmes and services that most directly affect health. It was the commitment to democratic accountability manifested through community mobilization to build fresh governance structures that gave New Directions its radical edge. Of course, it was just that element which provoked an irreconcilable policy controversy with doctors, nurses and other organized health care providers.

The explicit objective to reform the distribution of power in the health sector was connected to the approach that government used to develop and implement the New Directions policy. Rather than develop the reform within the bureaucracy, which in effect means in close consultation with the client groups of physicians and unions, the government deliberately established a parallel process that excluded the B.C. Medical Association and ministry of health officials. Government also excluded physicians from the implementation process. The doctors' sense of exclusion shaped their perception of the whole enterprise. Thus even when the government backed away from the community development model that New Directions dictated, and moved towards a more modest bureaucratic reorganization, the doctors remained angry and alienated. Their discontent was still felt six years after the announcement of New Directions, three years after its demise.

New Directions marked a departure from a pluralist politics that sought negotiated settlements between health care providers and state bureaucrats. It marked the launch of an innovative, reform politics – the politics of ideology. Consequently, it unleashed a lot of energy, both positive in the form of community activism and negative in terms of the reaction of organized interests. The health sector lurched from a heated competition amongst provider groups for resources to an even more heated policy confrontation between those providers and the government.
Several colliding principles ran through the health reform. Local democratic accountability collided with efficiency and administrative rationality. Flexibility and diversity collided with commitments to uniform terms and conditions for comprehensive health service delivery. Equity reinforced administrative rationality in opposition to the mutually supportive values of flexibility and local accountability. Perhaps most significantly, devolution collided with ministerial accountability (and political survivability). Experience was to show the minister could not, much as he or she would like, distance him/herself from poor ambulance response times, surgical waiting lists, hospital service disruptions, facility closures, or spectacular medical misadventures. Bitter experience showed that politicians needed detailed information about, and the means to control decisions at, the periphery. In the end, political needs, administrative rationality and efficiency trumped local accountability, flexibility and diversity.

The speed and ease with which the reform reverted to an administrative reorganization can be explained by examining the underlying institutional arrangements, the power relations they embed, and the ideas that legitimate them. Efficiency, equity and direct, unmediated interaction between organized providers and the ministry are values prized not only by the bureaucrats within the system, but also by the health care unions. They are also values informing key institutional arrangements. Moreover, the reform values of local democratic accountability and control, besides conflicting with union and bureaucratic norms and beliefs, are completely at odds with a medical perspective. The medical perspective rests on foundations of expertise and professional prerogatives. The collectivism implied in the conception of community health that underlies notions of community control of health services collides violently with the individualism of the medical profession and the doctor’s responsibility for his or her individual patient. The study shows how those ideological factors expedited the demise of the reform.

Health care managers must be able to work effectively with health care professionals in order to do their jobs. No aims of policy or procedure can be realized without (at least tacit) cooperation by doctors. This rather banal point leads to the less banal conclusion that managers cannot easily serve the purpose that government wanted them to serve – viz. to improve system efficiency through controlling health care professionals. As the study shows, management and doctors work closely, and by-and-large cooperatively, together. Many health care managers are also health care professionals. Managers and professionals share many beliefs and values. The managerial cadre, entrusted by government to implement the reform, in practice subverted it. Not only did they bring the experiences, norms and operating procedures from their previous roles in the ministry and hospital administration, their interests were more closely aligned with physicians and traditional health care institutions than with the goals of the reform.

A major goal of the health reform was to limit the power of the health care professionals. There is no evidence of progress on that front. In so far as power lies in shaping the perceptions of the public and other policy actors, a key dimension of structural power, doctors remained paramount. Health care professionals were remarkably successful in convincing the media and the public that: (1) the existing health care system is a good one, albeit seriously underfunded by government; (2) government controls adversely
affect the quality of care provided; and (3) the historic pact between the state and doctors enshrined in medical care insurance arrangements is a sacred trust and therefore beyond legitimate government interference. A fence was built around the health care system, protecting it from future government policy incursions. In short, failure of the 1993 policy reforms substantially narrowed the future range of publicly feasible health policy options.

While there is some evidence that the medical profession may be in the process of restricting the clinical autonomy of individual doctors through practice guidelines, the profession has done so only to strengthen collective professional power. Within care settings, there is no doubt individual doctors are more constrained at the close of the 1990’s than they were in the 1970’s by protocols and review processes. But those protocols and reviews are products of mutual accommodation between managers and doctors. As Klein (1995a) has pointed out, there is no reason to believe they affect the balance of power between doctors and managers. Moreover, the bureaucratization of the clinical practice of medicine is a function of hospital organizational development in the light of technological change and scarce resources. It is not a function of government policy, per se.

Turning to the outcomes of the B.C. health reform, the best starting place is the list of stated goals. The priority ones were: “closer to home”, improved patient access, fostering a community health perspective, and devolving control over health and health services to the community level. “Closer to home” required a shift of resources from acute institutional services to community-based ones. The study found no such shift occurred over the life of the reform; in fact, perversely, resources flowed away from community services and into acute care. While actual data on waiting times is contested, incomplete and confounded, both the public and the regional health board believed that patient access worsened over the course of the health reform. That is in spite of additional money that the government pumped into the system to defuse the “waiting list crisis”. The evidence regarding the community health perspective suggests that the public, by the close of the reform effort, was more concerned about conventional health care services and less concerned about community health than it was at the outset. There was no evidence of new community health programming.

At first blush, devolution appears more difficult to assess. Following three years of considerable confusion, regional bodies were established and, after 1997, enjoyed delegated spending authority. However, their scope of control was much less than envisaged by New Directions. In fact, the ministry had more direct control over hospital and community health services under regionalization than it had under the old model of autonomous hospital and community agency boards. The community had less. The planned community health councils were scrapped in 1996, and citizens had less connection with, and less influence over, regional health boards than they did over the locally-based hospital and agency boards that they replaced.
What, then, were the achievements of B.C.'s decade of health care reform? First and foremost, health care services were centralized and integrated at the regional level. Second, those services were brought more closely into the orbit of the ministry through its strict funding and policy protocols. Third, the major health care unions, through provincial bargaining arrangements that they won from the government by bargaining over regionalization, gained substantial power. Fourth, the organizational prerequisites were finally put in place for a drive to greater service integration, improved efficiency, and more management information. Fundamentally, though, the health care system in B.C. remained unchanged. Power was still brokered by professionals, providers and bureaucrats in a system governed by the rules established in the 1960's by the hospital and medical insurance plans. In short, the fundamental rules of the game did not change; there was only a minor shift in the pattern of winners and losers.

The case study is intended to be a contribution to research into the current state of, and the dynamics within, the welfare state. Its subject is health care, but could have easily been child welfare, education or housing. That suggests lines of further enquiry, specifically applying the concepts developed in the study to other fields of social and economic policy, not only in Canadian provinces, but also in other advanced welfare states.

In terms of health care policy, the study covers much of the same ground as recent studies in the United Kingdom. Butler (1992), Ham (1992) and Klein (1995a) are examples. Findings are remarkably consistent, commending the value not only of comparative health policy studies, but also of governments taking advantage of policy learning. With the benefit of hindsight, it appears many of B.C.'s policy implementation problems could have been mitigated by more careful attention to the British experience.

Finally, the study raises a number of questions suggestive of fruitful future research. First, the short-term results of regionalization may not be indicative of longer-term consequences, thus the embedded study should be replicated five or six years in the future. Second, there are differences amongst regions in B.C. and a comparative study examining those differences and the factors that led to them would be a useful addition to the programme of work undertaken here. Third, a comparative study of other Canadian provinces that underwent regionalization initiatives (for example, Alberta and New Brunswick) and of Ontario (which did not regionalize its health care services) would broaden the knowledge base and test the theoretical propositions advanced here.
Chronology of British Columbia Health Policy Reform

1991
➢ Election of New Democratic Party government headed by Mike Harcourt
➢ Royal Commission on Health Care and Costs (Seaton Commission) tabled their report

1992
➢ Medical and Health Services Act passed
➢ Royal Commission implementation committees (extra-ministerial) struck

1993
➢ Announcement by Elizabeth Cull of New Directions for a Healthy British Columbia
➢ Public Service Employment Commission (PSEC) and Health Employers’ Association of B.C. created by legislation
➢ Strategic Directions Division created in the ministry
➢ Community steering committees struck
➢ Health Labour Accord negotiated between government and major health care unions
➢ Health Labour Adjustment Agency formed
➢ Master Agreement between government and BCMA signed
➢ Health Authorities Act passed

1994
➢ Paul Ramsey replaced Elizabeth Cull as Ministry of Health
➢ “Fast-tracking” speech in February
➢ Transition teams established
➢ Interim Community Health Councils and Regional Health Boards designated
1995

- Denominational facility agreement finalized between churches and government
- Waiting list crisis erupts
- Tertiary care report (Lovelace Report) commissioned
- Medicare Protection Act introduced
- Change in deputy minister and demise of deputy minister’s advisory committee on *New Directions*

1996

- Government overwhelmed by “Bingogate” scandal; Harcourt resigned
- New Minister of Health, Joy MacPhail, announced review of *New Directions*
- Surprise re-election of NDP under new leader, Glen Clark
- Dorsey/Ready labour settlement imposed by government on employers
- Ministerial review recommends elimination of two-tier governance model and re-focusing on issues of health care service efficiency and effectiveness
- *New Directions* replaced by policy *Better Teamwork, Better Care*
- Interim RHB and CHC members dismissed by MacPhail
- New health authorities appointed in 44 regions and communities (down from *New Directions’* 102).
Acknowledgements

This study had a long gestation period. While itself a meso level study, its origins lie in macro welfare state theory. In this area I owe a debt of gratitude to a number of past teachers and colleagues. I especially benefited from my association with Don Carmichael and Tom Pocklington at the University of Alberta and Geraint Parry, Michael Evans and Raymond Plant at the University of Manchester.

The actual conduct of the study benefited enormously from the expertise and support provided by my supervisor, Morris Barer, and committee members Sam Sheps, Jim Frankish and Mike Howlett.

I enjoyed remarkable access to, and surprising candor from, labour union officials, senior bureaucrats, British Columbia Medical Association officials, regional health board members, and health care managers and providers. Without exception, they were helpful and constructive. Their differences of opinion were to be expected; the welcome surprise came in the form of their clear commitment to the health care system and the patients it is supposed to serve.

The study is dedicated to my wife Rhonda without whose support it would never have been completed.
HEALTH CARE REFORM IN BRITISH COLUMBIA: DYNAMICS WITHOUT CHANGE?¹

CHAPTER I: Purpose and Overview

1.1 Purpose

The purpose of the study is to understand the implications of the British Columbia health care reform New Directions for a Healthy British Columbia. Specifically, the study examines impacts on the exercise of power and the allocation of resources in health care delivery in British Columbia stemming from provincial policies of regionalization and devolution. The study also contributes to theory development regarding the policy implementation process by expounding and applying an approach to policy-as-ideology. Another subsidiary purpose is to contribute to theory regarding the power and accountability of health care providers and lay members of health services’ governance structures.

The study begins with an examination of the antecedents to the 1993 reform initiative. The Royal Commission on Health Care and Costs (Seaton, 1991) constituted the watershed. The Commission was the first comprehensive review of the health sector in British Columbia since the 1973 Report on the Health Security of British Columbians (Foulkes, 1973). The Seaton Commission was mandated to undertake a comprehensive review of the B.C. health care system. The government that convened it, however, did not survive the intervening election.² Thus the Seaton Commission tabled its report with a new government – one that had based its election campaign on health and social service reform. The year 1991 therefore marked an unusual “conjuncture” – the coming together of elements conducive to substantial policy change. That conjuncture, the election of a left-of-centre government and the tabling of the Report of the Royal Commission on Health Care and Costs, is the logical starting point for a case study examining health care reform in British Columbia.

¹ The title of this study is intended both to signal the similarity of findings with the early studies of Robert Alford and the theoretical debt the author owes to him. See Alford’s seminal study “The Political Economy of Health Care: Dynamics without Change” (1972).
² “Government”, this context, refers to the elected members of the political executive, specifically the premier and cabinet.
The study develops three broad lines of inquiry:

1. **How did British Columbia’s health reform policy – *New Directions* -- differ from the health policies that preceded it?** What ideological content did it incorporate? How and why did that content change over time, whom did those changes affect, and what was the significance of the changes? How are the perspectives incorporated in policy related to the perspectives of actors and coalitions engaged in the health sector? To what extent and in what fashion did the non-governmental and governmental agents interact?³

2. **How has the regional model of a chief executive officer assuming managerial control of hospital, public health and community health services under the direction of a government appointed citizen board:**
   - affected professional and managerial influence over resource allocations?
   - affected the relative position of the “Cinderella” community services *vis-a-vis* medical care and treatment services?
   - affected beliefs concerning the proper ends of public spending on health - *i.e.* fostered a shift from a traditional health services orientation towards a community health perspective?

   Why have those various effects occurred or failed to occur? This portion of the study (the embedded case study) concentrates attention on how regionalization and amalgamation affect accountability, control and the allocation of resources. It also measures the extent of the distributive effects.

3. **To whom, and for what, are the new citizen boards accountable?** What control do they exercise? How does their exercise of authority affect managers and other health care providers?

   In sum, the objective is to understand the implications and impacts on the exercise of power and the allocation of resources in health care delivery in British Columbia stemming from provincial policies of regionalization and devolution over the period 1990 to 2000.

³ **“Governmental”** refers to both the political executive and the permanent executive, *i.e.* the bureaucracy.
1.2 Design

The research design is an embedded case study design. The primary unit of analysis is provincial. The relevant time period is 1990 to 2000. Embedded in that case study is the study of one of the regional health authorities, the South Okanagan-Similkameen Health Region.

Since full fiscal authority did not devolve to the regional level until early 1997, the end-date of the study was set for the conclusion of the 1998/1999 fiscal year - March 31, 1999. The date is based on the assumption that the 1998/1999 fiscal year (the second full year of devolution to regional health boards) is the first opportunity the board can exercise planning and resource allocation autonomy. If the existence of regional boards makes a difference to spending priorities, that difference should be detectable by 1998/1999.

1.3 Background, Key Assumptions, and Theoretical Framework

The study is, in one important sense, a study of public sector restructuring. Regionalization, devolution, amalgamation, divestment and establishment of private-sector style boards with general managers are common strategies throughout the countries of the Organization for Economic Cooperation and Development, and across a number of sectors within British Columbia, including both health and child welfare services. Public sector restructuring, wherever it occurs, creates new roles and functions that reflect potential changes in power relations. Further, devolution, as a strategy, is not only a process of restructuring the policy delivery system, but also a process of transforming the policies. That process of transformation lies at the heart of the case study.

However, the study is not a case study of the general phenomenon of public sector restructuring, nor even one of health care devolution. First, on theoretical grounds, a case study is not a “case of something” in the sense that it is a sample of some population of like phenomena. Its generalizability is found on theoretical, not statistical grounds. Second, the health sector has important distinguishing characteristics. It is atypical of other sectors, insofar as professional considerations and organized professionals dominate it. A key theoretical tenet informing the case study is that this difference is best captured by the concept of ideology - the intersection of fundamental beliefs and values with entrenched interests and institutional arrangements.

Expressed less abstractly, the study is grounded in an observation that the provincial government’s initiative, *New Directions for a Healthy British Columbia*, began as a substantive reform that attempted to move existing, limited public funding away from medical and hospital services in the direction of “community health”. Community health
considerations encompass concerns with quality of community life, citizen engagement, income inequality, and other determinants of the health of populations (such as public education and incomes policies). Those concerns contrast sharply with concerns centred on the provision of health care services to individuals (such as access to, and comprehensiveness of, medical and hospital services). The community health perspective not only justifies moving resources from present service providers and applying them to other public concerns, but also challenges the legitimacy of health care professional dominance over matters relating to human health. The community health perspective is an ideology in the sense that its frame of reference informs beliefs, values and actions that directly affect the legitimacy, power and interests of health care providers.

The study advances the position that proponents of health policies centred on health care services, whether styled preventive, curative or caring, share a perspective or ideology regarding the nature and significance of health services, as well as an interest in maintaining or increasing public funding in their favoured sub-sector. Conflicts between, for example, community health service advocates and acute care advocates are to a considerable degree over their respective share of the available resources. They are not different in kind from, for example, intra-professional fee-for-service physician disputes over relative fee values. That is not to say all the beliefs and values are the same across different health provider groups, but rather that a common perspective, frame of reference or world view, coupled with a common interest in increased funding, informs them.

The rise and fall of support for a community health approach is thus a key variable in the study. The primary case traces the shifting orientation of health policy as it emerges through the configuration of, and interactions of actors from, the health policy community, starting from the government’s announcement of New Directions.

The study provides evidence to support the contention that the provincial government was sincere in its intent to reform the health sector. Reform entails substantive, structural change. And the changes envisaged included not only an attempt to make structural changes intended to improve community health, but also a reorganization intended to reduce the influence of health care providers and managers over resource allocations. Both goals were closely aligned with the objectives of controlling public expenditure and improving accountability.

Prior policy learning influenced the shape of both the expenditure and accountability measures adopted in the health reform package. Canadian provincial policy makers had discovered, through a host of cost-containment measures applied in the 1970’s and 1980’s, the limits of demand and supply controls in the health sector. That experience convinced policy makers that tinkering with pricing and payment mechanisms would not make the system more affordable or more efficient or accountable. Mounting public debt coupled with the limitations of conventional policy instruments made provincial policy makers more open to the ideas of academic health policy analysts.
During the 1970’s and 1980’s, the community health perspective became more prominent, especially in the thinking of increasing numbers of academic members of the health policy network. The claim that the significant variables influencing the health of populations lie outside of the health care system brought into question the role, privileges and achievements of health care providers (McKeown, 1979; Wilkinson, 1989; Evans and Stoddart, 1990). Concurrently, health economists construed rising health care expenditures as little more than a transfer of income from taxpayers to health care providers (Reinhardt, 1978; Evans, 1990). Academic advocates for reform focused on the lack of accountability of service providers to consumers and purchasers of health care (Day and Klein, 1987; Enthoven, 1989). Sociologists and political scientists claimed discovery of the self-serving nature of health professional organizations (Friedson, 1970; Alford, 1975; Starr, 1982).

Through mechanisms such as interaction with Federal-Provincial health advisory committees, direct contact with officials in provincial ministries of health, participation in government sponsored studies and commissions, and advocacy by groups who saw their interests advanced by it, the academic community’s perspective increasingly came to the government’s attention. The major goals of health reform in British Columbia (fostering a community health orientation and reducing provider influence) demonstrate how the government’s views had come to reflect the emerging academic community’s perspective – what this study refers to as the “community health frame”.

By conceptualizing policy in a way that links provider accountability to a community health perspective, and both of those to cost-containment, health reform advocates confronted fundamental interests constellated around health resource allocation decisions. The primary case study begins by assuming that the confrontation can be explicated in terms of a divergence in ideology between professionals and service providers on one side and the provincial government on the other. It ends by showing that the reality was a good deal more complicated.

The study shows that the combined effects of conflicts amongst objectives, conceptual and practical difficulties, the ideas and patterns of behaviour embedded in institutional arrangements, and the reaction of institutional actors resulted in the transformation of significant reform into a modest bureaucratic reorganization. Consequently, the only significant medium-term effects were an intensification of the long-standing effort to shift resources at the margin towards community-based services, (ironically given the community empowerment agenda) enhanced governmental control of planning and spending, and growing influence by organized labour and managers over health care service delivery.

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4 For example, public health coalitions and professional nursing organizations have a material interest in shifting power and resources away from active treatment physicians.

5 In 1986, Canada hosted the first International Conference on Health Promotion. The delegates produced the Ottawa Charter. It stressed that the medical system cannot maintain a population’s health (World Health Organization, 1986). The themes of the Ottawa Charter resonated with provincial ministers of health who were all seeking a rationale for curbing health care expenditures.
"Policy reform" is used here to mean a fundamental change in perspective that informs organization and action. Consequently, both the perspectives incorporated into health policy and the degree that they found expression in organizational forms must be examined to determine the extent of reform. Implementation of a policy reform requires a new perspective on the policy area to arise and come into dominance. Change requires either successful mobilization of the policy community around those ideas, or the delegitimation of the existing community and establishment of a new policy regime. Either way, change requires incorporation of the new ideas and values into legal and organizational (i.e. institutional) forms.

The perspectives informing B.C. health policy shifted during implementation, primarily as a result of the failure of government to build a coalition with sufficient power and cohesion to upset the dominance of the traditional perspective and the interest groups it serves. That shift, together with the failure to institutionalize the new perspective early enough in the process to block organized opposition, proved fatal to the health reform effort.

The study requires the identification of alternative perspectives and an explication of their significance. An important part of the primary case study is illustrating the shifts in those perspectives found in the various iterations of the government’s health policy. The study also explains why the perspectives changed over time, whom those changes affected, and what further changes ensued. The connection between policy iterations and the perspectives of institutional actors engaged in health delivery policy is explicated in terms of recent policy community theory.

The expression and transformation of the policy perspectives is inferred from governmental and non-governmental documentary evidence. A second stream of evidence flows from interviews with key informants drawn from the organizational actors engaged in health policy formulation and implementation - health provider organizations and officials in the provincial bureaucracy. Similarly, the interactions, levels of mobilization, and effects of the interaction are inferred from documentary and interview evidence.

The study examines the proposition that advocacy activity changed in degree and direction as government’s policy commitment shifted away from a community-centred reform towards more modest goals of cost-containment and greater accountability to the government for expenditures. The examination of perspectives shows that the fundamental beliefs and values informing the 1993 policy direction were incompatible with the fundamental beliefs and values of the health professionals and providers. It is theorized that the size and nature of the disjuncture shaped the nature and extent of the response of health professionals and providers. It is further theorized that as the position incorporated in policy grew more congruent with the position of dominant actors, patterns of interaction returned to earlier forms and themes. The study demonstrates that successive iterations of policy increasingly aligned policy content with the pre-reform perspective, and hence with the interests of the traditionally dominant actors.
Analysis regarding policy community activity involves a study of the members and interaction amongst the organizations within the health policy community to demonstrate shifts in the nature and level of activity within and amongst organizations concurrent with the shifts in policy content. Evidentiary sources are the same as those identified for the propositions on policy content, but also extend to regional board documentation and regional board chair interviews.

It is theorized that the degree of policy commitment to reform and the nature and degree of interaction are related. Degree of policy congruence with the prevailing perspective of the dominant organized interests is the decisive variable. Underlying this are several related theoretical propositions drawn from the policy community literature. A reform policy will provoke reactionary politics. The more fundamental the reform, the stronger the predicted reaction by those whose interests are adversely affected. Potential actors whose interests are negatively affected are more likely to mobilize and react more strongly than those whose interests are positively affected. When confronted by strong, organized reaction, a weak government with poor conceptualization of policy will increasingly improvise, which in turn will expedite concessions and a return to the status quo.

The aforementioned theoretical propositions structure the case study. From this stance, the nature of the policy process can be disclosed by determining which groups mobilize, the strength and content of their beliefs, the nature of their perspective, and the intensity of their involvement. This process of disclosure reveals the ideological foundations of power. It also reveals serious limitations in the conventional approach to power and interests.

However, an examination of the perspectives underlying (the ideological dimensions of) the health reform process does not dispose of the question of power. The provincial government, whatever the twists and turns in its health policy, did succeed in operationalizing a model of regionalization of health care services. Regionalization and amalgamation have potential distributive effects; some institutional actors are worse off, others better off, as a consequence.

For completeness, the study must extend to the questions:

(a) do regionalization and amalgamation affect accountability, control and the allocation of resources? and
(b) what is the extent of the distributive effects?

The study postulates that neither the citizen-board governance nor the general management models that emerged at the regional level affected the fundamental distribution of power and the resultant flow of resources. Analysis involves examining: (1) how have the policy and organizational changes affected the accountability of, and the scope of control exercised by, physicians, managers and boards; and (2) the flow of resources to the various health services’ sub-sectors.
That analysis requires a micro study conducted at the regional level. This “study within a study” is a common case study design, referred to as an “embedded case study” (Yin, 1994).

Both levels of the case explore whether and to what extent the reforms proposed in *New Directions* and the government’s efforts to implement those reforms threatened health care professionals and providers in the following ways:

1. an ideological shift to community health undercuts the legitimacy of health care providers’ claims on public resources;
2. amalgamation reduces practice sites and jobs;
3. the integration at the community level of clinical and community services blurs borders upon which professionalism relies;
4. community boards lend legitimacy to people other than providers to manage health care services; and
5. stronger control, whether community or governmentally vested, may lead to decisions being made on bureaucratic and budgetary grounds rather than based on the needs of patients or clients (Light, 1997).

Resistance by professionals such as physicians would be expected on all five grounds. Unionized health care providers would be expected to resist possible job losses. They may also be concerned about professional boundary issues, citizen governance, and impact on patient care. The study explores the form and outcomes of both professional and job protection reactions, the responses of the other members of the policy community, and the implications for policy.

The primary case deals with all five threats as they played out amongst the principal actors at the provincial level. The purpose in examining the relationship between the sets of ideas expressed by the institutional actors, their behaviour and the policy outcomes is to disclose the dynamics of policy change. The case demonstrates how government concessions to health provider unions over job protection and concessions to physicians over the management of primary care undercut the perspective that served as the philosophical base for the reform. The study advances the position that the demise of the reform perspective may be best understood as a reversion to the dominant ideology informing health care institutions – in effect, a retrenchment that favoured the traditionally dominant interests.

The embedded case deals with only threats 3, 4 and 5. Those three threats are closely related from a strategic point of view. Policy success on any one of the three fronts facilitates movement on the others. Rather than examining the responses of health professionals and other local factions to those threats (and the effects of those responses)
the embedded case deals with the actual changes that occurred in accountability, control and resource allocation.

Both primary and embedded cases rely on triangulated evidence to ensure construct validity. The primary case relies on data obtained from:

1. the examination of government (ministry and political) policy documents, the Ministerial review of New Directions, Ministerial speeches, the Health Authorities Act (as enacted, as amended, regulations pursuant to it), Ministry of Health directives to regional boards, and media reports;
2. key informant interviews with senior government officials in the Ministry of Health;
3. key informant interviews with union and professional body leaders;
4. documentary review of position papers, newsletters and related documents from professional and health provider organizations.

As already outlined, both documentary and interview evidence demonstrate that commitment to community health, citizen governance, devolution and related structural reforms declined over the period 1991 to 1998. Societal policy actors’ advocacy activity changed in degree and direction, from obstruction of reform to traditional lobbying for resources and influence. It is theorized that the two are linked, and can be understood through the “policy-as-ideology” framework that is developed in the second chapter.

It is recognized that even if health professionals and providers retained the upper hand, and drove provincial policy in directions more congruent with their interests, health service professionals and providers at the local level may not have retained their historic influence under the new regional management authorities. Assuming one key goal of the health reform was increased accountability of health care providers, it is possible to cede provincial policy ground on professional and labour union issues, while still attaining some accountability objectives through organizational change. Further, the nature and authority of the new structures were contested both provincially by the major institutional actors and locally by diverse interest groups. Those considerations necessitate a study of the nature of regional structures as they emerged, their authority, accountability and control, and, most importantly, their actual impact on health professionals and providers.

The embedded case, the study of the Okanagan-Similkameen Health Region, relies on documentary evidence comprised of board documents, direct observation, and key informant interviews with board members, the chief executive officer, medical staff representatives, nurse managers, and community agency staff. Changes in hospital and agency reporting relationships and requirements are analyzed, as is the context of

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6 It is also possible that government “beat a strategic retreat” in order to pursue reform goals through different governing instruments - for example, regulation or direct caps on professional earnings. The government’s approach to organized labour and the BCMA is reviewed in chapter 6.
decision making regarding resource allocation. A survey of first-term board members captures their perspective on the impact of *New Directions*, regionalization and citizen board governance.

The starting point for the embedded case study is an analysis of how "board governance" and "general management" affect the position of health professionals and managers with regard to resource allocation at the regional level. The study then seeks evidence regarding diminished professional influence. Generally speaking, the findings suggest that, to the extent that greater accountability measures are found, they are primarily located in front-line staff care by nurses, technicians and other salaried health care providers. That finding supports the principal finding of the primary case - *i.e.* that structural reform changing the actual distribution of power did not occur.

The embedded case also involves an analysis of budgets and expenditure reports to determine if there is empirical evidence of:

- resource reallocations from clinical to non-clinical services
- resource reallocations from hospital and allied services to "Cinderella services".

Again, the findings suggest that regionalization failed to reverse the patterns of resource allocation. In fact, resources actually flowed *away from* the Cinderella services into acute care.

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7 The quantitative analysis of resource flows is, strictly speaking, outside the case. It is nevertheless important. A significant shift of resources would be suggestive of, albeit not definitive evidence for, a change in power configuration. It is certainly a test of a key objective of the government's reform initiative - more funds for community health and health promotion. More directly germane to the case is the question "Why and how did the change in resource flows occur".

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1.4 Theoretical Significance

1.4.1 Primary Case

The primary case, the study of New Directions' implementation (1993 to 1996) and subsequent Better Teamwork (1996 to 1998) health reform initiative, is designed to explore the strengths and limitations of the theoretical models developed in the policy community literature. The study expands the theoretical understanding of the role of beliefs, values, interests and ideology within the tradition of policy community studies. The policy community theoretical tradition is particularly germane to the proposed study. The British Columbia health sector is characterized by the prominent role of institutional actors in health policy formation and implementation, the strongly held values and beliefs of participants, competing policy perspectives, and close, regular interaction amongst health care professionals, unions representing health care providers, and government officials.

The claim that "dominant structural interests" (Alford, 1975), characteristic of the health sector up until the 1970's, have given way in the health sectors of modern capitalist societies to more porous policy communities open to greater "policy learning" (Pal, 1997; Sabatier, 1993) is examined as one of the limiting conditions of the advocacy coalition framework and network theory generally. Approaches to the inclusion of power and ideology are explored in that context. That exploration contributes to longstanding theoretical concerns regarding pluralist approaches to power and policy and more structuralist ones drawing from the sociological traditions of Marx and Weber.

One of the key problems that must be addressed in this study is the dispute between theorists who hold that pressure group activities (Sabatier’s advocacy coalition model being only one example) shape policy and those (for example, Alford) who hold that pressure group activities grounded in beliefs and values co-exist with more fundamental struggles between “structural interests”. Structural interests are understood as institutional actors who benefit from the prevailing institutional arrangements and the ideas that legitimate them. Structural interests are, in this view, more significant in determining the overall distribution of resources, and in shaping the main contours of power relationships. The medical profession is widely regarded as the paradigm case. The professional ethic, the legal protections, the “medical model” of health care, and the way roles are defined within health care organizations all advantage doctors. Skirmishes with other health care providers and encounters with alternative perspectives on health care may influence individual decisions and specific outcomes but have only marginal effects on the institutionalized power of the profession and the broader pattern of results.\(^8\)

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Analysis of the primary case deals explicitly with what has been deemed to be an under-theorization in the existing literature of key concepts such as power, knowledge, and policy learning (Pal, 1990). That analysis addresses a second key problem in the literature. Theorists generally adopt a position that is explicitly power-based and focused on the conflict between policy actors or, alternatively, adopt a position that is information-based and focused on learning. Neither is adequate. The intent of this study is to build on a suggestion by Atkinson and Coleman to reach beyond conventional policy community analysis “to posit the structural conditions under which interaction occurs” (Atkinson and Coleman, 1992). The analysis demonstrates why the structure and history of the policy community matter, as does the institutional and ideological context into which they fit. The second chapter develops a synthetic approach that strives to transcend the limitations of “power based” and “ideas-based” policy analysis through exploring the implications of history, structure and ideology.

1.4.2 Embedded Case

Two related theoretical positions are examined through the embedded case study. They are:

- theories of diminished professional power based on the conceptualization of professional and managerial conflict over the control of health care resources in the context of general or executive management of health services (Green, 1975; Scott, 1985; Harrison & Nutley, 1996);

- theories of countervailing powers and community participation as counterweights to professional dominance (Light, 1997; Mechanic, 1991).

The lines of argument run in opposing directions. Light, representing one direction, argues that forces inherent in both community participation and bureaucratization enhance professional accountability, reduce professional autonomy, and facilitate more rational allocation of resources. His position is in many ways a classically pluralist one. Harrison and Mechanic, representing the other direction, argue bureaucratization is in fact a mechanism for consolidating professional control. Mechanic goes so far as to argue the power of professional medicine (professional dominance over resource allocation) is growing.

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9 The two theoretical postures are linked. Treating policy as an output of pressure group or coalition activity and regarding the engines of the activity to be either pursuit of interests or learning processes draw from a rational actor model, an individualist methodology, and an empiricist epistemology. They share a (defective) conception of power. These theoretical issues are pursued in chapter 2.
Regionalization in British Columbia provides an ideal test case for these competing theoretical orientations. Both the thesis of citizen participation as a countervailing power over professionals and the thesis of bureaucratic power can be fruitfully examined in light of the developments in the Okanagan-Similkameen Region.

The embedded case examines these issues from several angles:

- How have decision structures changed?
- Who is accountable for what, to whom, how?\(^\text{10}\)
- How much control can regional boards exercise?
- How has regionalization affected the distribution of resources?

\(^\text{10}\) This portion of the study partially replicates the Day and Klein study on accountability of, and control by, health boards in Britain (Day and Klein, 1987).
1.5 The Case Study Approach

A case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident. (Yin, 1994; p.13)

The unique strengths of a case study design are the abilities to deal with a full variety of evidence - documents, interviews and observations - relating to a contemporary phenomenon. The approach is essential if the underlying theoretical perspective holds that the meaning of the phenomenon under study can only be determined in its context. That is, in fact, the dominant view in the policy literature.

A case study is neither “descriptive” nor “qualitative”. A case study can be informed by, and designed to test, theory. Its findings can be based on any mix of qualitative and quantitative methods and measures.

As a design, it is suited to “how?” and “why?” questions (Yin, 1994). For example, the question “how and why do agencies within newly amalgamated regions collaborate” is suited to a case study. The question “to what degree do they collaborate” is suited to a survey. The questions raised by the proposed health reform study are clearly of the former sort.

An objection to a case study is that it risks being partial and incomplete. The issue of incompleteness was well addressed by Rob Flynn:

“In the absence of a coherent, integrated and universal theory which can account for all types of action/non-action, which explicates the relation between structural constraints and individual discretion, and which unravels the linkages between agencies and institutions at different levels, we must be more modest and pragmatic . . . our endeavours will be limited, partial and provisional” (Flynn, 1993; p. 61).

Another common view is that case studies are unrepresentative. Phrased another way, they cannot be generalized and therefore fail the test of external validity. It is true that poorly designed, atheoretical and eclectic case studies lack generalizability. It is not true of explicitly theory-informed case studies whose express objective is to generate more robust theoretical propositions with broader applicability.

The proposed use of case study design is explicitly theoretical. It is analogous to a natural science experiment, observing the bending of light during an eclipse to test Einstein’s physics, for example. Such an experiment is not a sample, it is not representative of anything, it is not a member of a population, and it is in no way statistical or quantifiable. Rather it is a test of a theoretical proposition with a view to
refining the theoretical foundations of a discipline. (Campbell, 1969). In other words, the more robust the theory, the more cases it can accommodate.\footnote{Yin refers to this as ‘analytical generalization’. “In analytical investigation, the investigator is striving to generalize a particular set of results to some broader theory.” (Yin, 1994; p.36)}

Reliability refers to whether repeated independent measurements by the same method will yield consistent results (Yin, 1994). Case studies are often claimed to be unreliable. That may be so in practice, but does not reflect a limitation of the research design. A case study demonstrates reliability if, and only if, another investigator applying exactly the same methods in exactly the same way achieves consistent results. Reliability boils down to, in the context of a case study, careful operationalization of the steps, a clear data collection protocol, and a comprehensively recorded database. The problems are the familiar experimental ones of rigour, documentation and avoidance of bias (Goldenberg, 1992).

Arguably more fundamental than reliability is construct validity (Yin, 1994). Construct validity refers to the application of correct operational measures for theoretical concepts. Manifest specifications of a phenomenon must be drawn up in order to measure it. For example, Dahl (1976) specified the relationship between an outcome of a decision making process and the preferences of the actors to be the indicator of the power of the actors engaged in that process. Drawing from several sources of evidence – a procedure known as triangulation – improves construct validity. Comparing the consistency of results from the examination of documentary and interview sources is an example of triangulation in this study.

A second approach to construct validity is to compare findings with the findings of authors who used different approaches. In this regard, the study compares key findings with the findings from studies of regional health care governance in the United Kingdom (Ham, 1992; Day and Klein, 1987) and with findings from recent Canadian studies on provincial health regionalization (Lomas, Woods and Veenstra, 1997). Wherever possible, more than one operational definition and more than one data source is used, since a high degree of agreement of findings across measures confirms construct validity.

Internal validity refers to the extent to which it can be shown that certain conditions lead to certain outcomes. Why is the explanation offered superior to alternatives? Internal validity can be a serious weakness of case studies. The approach adopted in the proposed study is the one pioneered by Campbell - “pattern matching” (Campbell, 1969). Possible confounding and rival explanations are compared alongside the proposed explanations against the patterns of evidence that emerge from each stream of enquiry. That process is necessarily iterative, one of developing propositions that are free from internal contradictions, that account for all of the findings, and that account for the findings in a way that is more plausible than alternatives (Yee, 1994; Goldenberg, 1992).
Proposing to treat health reform in British Columbia as a single case of interest may be objected to as "a study of a sample of one". As already argued, that would be a mistake, because the case is not "a case of something" drawn from a population. Rather, it is a suitable subject for study because, according to the theoretical propositions informing the study, the B.C. approach to reform directly challenged professional power. It is therefore both a test case of theories of professional power, and a test case of theories of public policy making in an ideologically charged context. Following Campbell’s idea of "reforms as experiments", British Columbia’s health reform initiative can be taken advantage of as a natural experiment.

Given the nature of the project envisioned in the study, the alternative to a single case design, a comparative case study, would add nothing except complexity. Comparative case studies would be most useful for exploratory research, not theory development of the kind envisioned here.

The choice of a single health region is defensible on the same grounds as taking the single case of B.C. health reform. The region chosen is not representative in the statistical sense. Rather the region chosen must be “representative” in the sense of being an interesting case, illustrative and informative, an “ideal type” from which inferences in the form of analytical generalizations can be drawn. The South Okanagan-Similkameen region does have features of an ideal type for the case study.

Amongst its relevant features are:

- a peer group II hospital\textsuperscript{12}, a second referral hospital, a number of smaller hospitals, intra and inter-regional referral patterns - in short, an intricate and multi-leveled institutional care system;

- a full-range of clinical and community services, including rehabilitation, cancer treatment, and tertiary care;

- a balance amongst urban, small town and rural populations and health care services;

- a reputation of being one of the most successful and progressive of the new health regions;

- a reputation of having one of the most competent boards and administrative cadres.\textsuperscript{13}

\textsuperscript{12} The Ministry of Health groups hospitals based on capability, case mix and size. “Peer group II” hospitals are full-service, major referral centres. They are general hospitals, and offer a broad range of acute care services, including intensive care and cardiac care. They do not, however, provide highly specialized tertiary care services such as complex neurological or thoracic surgery.

\textsuperscript{13} The Institute of Health Promotion Research (IHPR, 1998) found the S. Okanagan-Similkameen Regional Board to be one of the most functional of the new governance structures.
Those attributes are important, since the objective is to determine the results of the health care reforms in a model that appears to be working. A dysfunctional region, or one that is wholly urban or rural, or a region that lacks breadth in services and organizations, would not make a good test case. Results would lack analytic generalizability.
CHAPTER II: Conceptual Framework

The chapter provides the background to, and the defense of, the theoretical position informing this study of health reform in British Columbia. It outlines the origins, strengths, and shortcomings of the policy network and policy community literature. The chapter introduces the idea of policy-as-ideology, and defends it as an approach that can tie together knowledge, interests and power. The chapter also demonstrates the alignment of methods with theoretical approaches, explaining why qualitative methods are appropriate to the study undertaken here. The chapter ends with a synopsis of the approach to data collection and a discussion of how that approach ties in with the research questions outlined in the first chapter.

2.1 Background to the Policy Community Approach

Political science was dominated in the 1950’s and 1960’s by systems theory and pluralism. Both were decidedly society-driven models positing an open policy process. Pluralism can be defined as a system of interest representation in which the constituent units are organized into an unspecified number of multiple, voluntary, competitive, non-hierarchically ordered and self-determined (as to type and scope of interest) categories which are not specifically licensed, recognized, subsidized, created or otherwise controlled in leadership selection or interest articulation by the state and which do not exercise a monopoly of representational activity within their respective categories (Schmitter, 1979; p. 15).

Pluralism is an empiricist (behaviourist) theoretical framework with an individualistic methodology. That is, it assumes statements about the interests of groups are statements about the individual preferences of group members. Groups advance claims by exerting influence through mobilizing various resources. The underlying worldview is a system model of politics. Groups are theorized as part of the political system, but not of the governmental sub-system. Groups are theoretically central because of the behaviourist methodology. In other words, groups are the visible and accessible actors with observable behaviours that form the subjects of empirical research.

Public policy, government action generally, is seen as reflecting the various interests of society. The model has no independent conception of the state. Rather the state is

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14 The most influential pluralist theorists were the American political scientists David Truman (1951) and Robert Dahl (1961).

15 In this study, “state” means all levels of government (municipal, provincial and federal in the case of Canada), their political executives and their associated bureaucracies.
formulated as the government function of interest mediation. Individual bureaucratic departments may, however, be interest groups in their own right.

The main functions of an interest group are to aggregate the interests of its members and to press for an outcome in the decision making process that furthers the group’s interests. Power is theorized as “success”, defined as attaining the group’s desired outcome. It is therefore directly observable, as it must be to be amenable to empirical research. The theoretical framework consequently drives the conclusion that the lack of activity on the part of a group signals consensus or a lack of interest. Power is relational and zero-sum in the model. If one group succeeds, another fails.

Capacity to organize and mobilize resources is assumed to be freely available to all. Pluralists do not, however, make the absurd assumption that all resources are equally available. Rather, pluralists make the softer assumption that those who lack one resource can mobilize another.

Summing up, the project of pluralism is to explain why some groups succeed in getting what they want whereas others do not. Explanation takes the form of an empirical analysis of resources mobilized by competing groups.

The first countercurrent to the dominant pluralist stream was the development of the concept of “sub-governments”. In the 1960’s, critics within the pluralist tradition identified some policy areas that were dominated over long periods of time by a limited number of actors, whereas other policy areas were fragmented, open and indeterminate. American scholars also noted that groups would align with both U.S. congressional committees and with the bureaucratic agency responsible for formulation and implementation of policies of interest to the group. “The politics within each system is built upon a triangular trading pattern including the central agency, a congressional committee or sub-committee and the [interest group] . . . each side of the triangle complements and supports the other two” (Lowi, 1964). In addition to these so-called “iron triangles”, research demonstrated how interest groups operating in areas of high information requirements or specialized resources could “capture” the public agencies mandated to regulate them. That could happen because the latter became dependent on the former for information or other resources. Groups that succeeded in forging iron triangles or capturing public agencies came to be known in the literature as “sub-governments”. The concept was subsequently broadened to describe any routinized pattern of interaction between interest groups and the state. The general picture of policy making that emerged was one dominated by closed, elitist groups, managing the policy agenda in terms of the interests of their members.

Heclo’s work on public policy (Heclo, 1974, 1978) constituted the first major counter-attack by a pluralist theorist on the notion of sub-governments. He demonstrated that some areas of U.S. policy making are characterized by open “issue networks” typified by disaggregated power. Heclo focused attention on the profound differences across policy areas. He contrasted, for example, the formulation of health policy with education policy
and with economic policy, not only across sectors within a country, but between sectors across countries.

From Heclo's work emerged the concept of the "policy sub-system". The policy subsystem is the constellation of state and societal actors who interact to influence policy development within a given sector.

A second countercurrent to the pluralist mainstream was the assertion by a growing number of theorists that the state had a significant, independent role in the policy process. The state has "the capacity to define legitimate interests, shape political organization, and incorporate societal actors into policy making" (Atkinson and Coleman, 1992). "Neo-institutionalism", the movement "to bring the state back in" (Nordlinger, 1981; Skocpol, 1985; March and Olsen, 1989; Peters, 1992), sought to correct the misleading pluralist notion of the state as a reactor to, or mere mediator of, societal interests. Political institutions, constitutional arrangements and the prevailing set of institutions mediating between governmental and non-governmental bodies returned as key variables in policy analysis.

A third counter current flowed from the European literature on the interpenetration of major societal and state actors such as business, labour and government. This "corporatist" literature emphasized the mutual interests of the state and major economic players in developing joint mechanisms that serve their respective purposes (Schmitter, 1982).

_Corporatism can be defined as a system of interest representation in which the constituent elements are organized into a limited number of singular, compulsory, non-competitive, hierarchically ordered and functionally differentiated categories, recognized or licensed (if not created) by the state and granted a deliberate representational monopoly within their respective categories in exchange for observing certain controls on their selection of leaders and articulation of demands and supports._ (Schmitter, 1979; p. 13)

Cawson (1986) advanced a macro theory that supported his meso-level proposition that the major function of business and labour groups in advanced capitalist states is to mediate between the state and their respective memberships.

The counterstreams to pluralism converge on three fundamental points: (1) different policy sectors have different configurations of actors, and therefore dynamics; (2) the state enjoys a degree of autonomy vis-a-vis organized societal interests; and (3) there is an interpenetration of the public and private spheres.
2.2 Policy Communities and Networks

A policy community/network approach quite consciously attempts to overcome a number of shortcomings of the pluralist framework. It builds on the insights of the elite theorists, the neo-institutionalists and the corporatists. Specifically, the approach holds that:

- activity cannot be understood outside of its organizational context; structural changes produce new conceptions of interests and new opportunities for organization - "new policies create new politics" (Schattschneider, 1960);

- the pluralist assumption of the dispersal of power cannot be sustained (Bachrach and Baratz, 1962);

- lack of activity is not equivalent to consensus or lack of interest; rather it may reflect "non-decision making" - power may be mobilized to keep issues from surfacing (Bachrach and Baratz, 1962);

- some policy sectors are dominated over time by a small set of actors (Lowi, 1964);

- it is a mistake to regard causality running from groups to policy; policy also affects groups (Lowi, 1964);

- not all groups are equal; corporate business interests prevail in liberal capitalist societies (Lindblom, 1977);

- some policy systems do not exhibit the porosity, fragmentation and ease of access assumed by pluralists (Schmitter, 1979);

- the ability of the unorganized to mobilize and countervail the power of entrenched interests is limited, and to a significant degree shaped, by those interests (Alford and Friedland, 1985);

- groups may be created deliberately by the state for state purposes (Pross, 1986);

- group power is not merely a function of the group's resources; power may turn on the state's recognition of the group and state power is partly a function of groups (Marsh and Rhodes, 1992).
The policy community/network approach grounds analysis in policy domains. Policy domains are sets of actors with preferences and concerns that must be taken into account by other actors in that domain. The approach suggests such domains can be arranged on a continuum from loose “issue networks” to tight “policy communities”. Both are “extra-constitutional policymaking arrangements between state representatives and clientelistic groups” (Boase, 1996). Their characteristics and forms of interaction are dependent on the institutional and policy environment in which they are situated.

Rhodes (1984) and Marsh and Rhodes (1992) made a major contribution in terms of theory development and analytic rigour. They operationalized concepts of restriction, entry criteria, norms, insider and outsider groups, core and periphery and primary and secondary communities. A policy community, on the one hand, is stable over time, characterized by state and societal insiders, in a close ongoing relationship. The policy community as a whole shares beliefs and norms. A network, on the other hand, is shifting, members enter and exit, interactions are erratic, and internal relationships may be conflictual.

According to Rhodes (1997; p. 43, 44):

A policy community has the following characteristics.

- A limited number of participants with some groups consciously excluded.
- Frequent and high quality interaction between all members of the community on all matters related to the policy issues.
- Consistency in values, membership and policy outcomes which persists.
- Consensus with the ideology, values and broad policy preferences shared by all participants.
- All members of the policy community have resources as the links between them are exchange relationships.

Rhodes argued policy networks matter. They are, in his estimation, the keys to understanding interest aggregation and intermediation. He held they are important for six reasons:

- They limit participation in the policy process.
- They define the role of actors.
- They decide which issues will be included and excluded from the policy agenda.
- Through the rules of the game, they shape the behaviour of actors.
- They privilege certain interests, not only by according them access but also by favouring their preferred policy outcomes.
- They substitute private government for public accountability. (Rhodes, 1997; p. 10-11).
Marsh and Rhodes (1992) demonstrated how resources like information and legitimacy are traded for positions in the policy process. They also demonstrated how governments might foster policy communities in order to depoliticize a policy area. Further, they theorized how a policy community institutionalizes a prevailing distribution of power while at the same time encapsulating a perspective on the policy sector.

Policy communities can actually increase state autonomy by establishing a means through which state actors can intervene in society without recourse to coercive policy instruments. For example, a delegation of state power to a professional body may give the state influence over the members of that profession that it would not otherwise have without explicit state regulation (Alford, 1975; Starr, 1982). The profession simultaneously gains legitimacy and influence. Power is not zero sum. The autonomy of non-state members of the policy community may also be increased by the state excluding other interests and perspectives. That can take many forms, from simple preferred access to legislating privileges and protections.

\begin{quote}
State actors need interest groups to provide information, to legitimize policies and to assist in policy implementation. Interest groups need state actors to have an influence on the contents of public policy. What is more, if relationships between state actors and organized interests develop into tight and closed policy networks, they then create stability and predictability in the policy process which is a major advantage for both the state actors and the interest groups (Daugbjerg, 1998; p. 2).
\end{quote}

Flowing from this is the notion of state capacity. A coherent state (or a state actor with sufficient capacity) can create the conditions for a policy community, which in turn increases state capacity. A fragmented state (or a state actor with low capacity) cannot effect the systematic exchanges needed to foster a community. The theory predicts that a fragmented political system such as the American one will, in most sectors, have networks. The weak state and loosely aggregated interest structures will reciprocally reinforce the fragmentation. A network dominated policy system results in policy inertia or constant tinkering depending on the current balance of forces. Thus America is stubbornly pluralist, highly politicized and has the policy style of “disjointed incrementalism” (Lindblom, 1977). Contrariwise, a strong, unified state such as the U.K. is predicted to have policy communities functioning in most sectors, strengthening the state, and fostering coherent policy.

From a theoretical perspective, the approach is distinctive with regard to both policy outputs and power. Policy outputs are not conceptualized as the successes of competing groups, but rather the results of actors occupying roles and making choices structured by commonly held norms and beliefs from amongst a set of institutionally determined options.

\begin{itemize}
\item March and Olsen (1989), Atkinson (1989), Smith (1994) and Boase (1996b) have developed the concept of state capacity as a variable affecting policy change.
\end{itemize}
From the time of setting out the elements of the conceptual framework (Rhodes, 1984) to fleshing it out (Marsh and Rhodes, 1992), fellow British political scientists Wilks and Wright (1987) substantially modified it. They redefined the key terms of policy network and policy community. “Community” was applied to all actors and potential actors who “share an interest” in a policy area (Wright, 1988; p. 606). Besides reversing the traditional nomenclature of “tight communities” and “loose networks”, the reformulation shifted attention away from material interests to the identity of actors and their beliefs and values. Wright, for example, focussed analysis on membership, core values and behavioural norms within sub-sectoral policy networks (Wright, 1988). Subsequently, “policy community” became (in the American literature and the minority British literature) increasingly associated with actors who share attributes regarding knowledge, ideas and expertise about a policy area. “Network” came to refer to the subset of those actors who share a material interest in policy outcomes (Howlett and Ramesh, 1995). Many Canadian scholars such as Coleman and Skogstad (1990) and Boase (1996a) followed Wilks and Wright in their use of “network” and “community”. But, with the exceptions of Howlett and Rayner (1995) and Hoberg (1996), few have recognized the theoretical importance of the differences between Rhodes and Wilks and Wright. Consequently, few have avoided conflating ideas with interests, thereby misrepresenting the roles of both.

Summing up, the project of policy community/network theory is to explain how networks characteristic of specific policy arenas have arisen, the nature of the relationships, and the consequences of the features of the network on policy formation.

The varieties of community and network theory are complex and confusing, partly because there are different epistemological and theoretical assumptions at work. Broadly speaking, the British literature can be pegged as an interest-based account that drew on epistemology and theory from Marxian and Weberian traditions regarding structural determinants whereas the American literature was rooted in rational actor models. For example, Rhodes’ work drew explicitly from the European literature on inter-organizational relations (Rhodes, 1997; p. 36). Other British theorists cite Giddens’ work (Giddens, 1984) on structural causation and the determinants of social action (Smith, 1993, for example). In contrast, the knowledge oriented version of community and network, associated most closely with Sabatier (1988), shared much more in common with the mainstream pluralist tradition. It maintained the focus on putatively rational actors pursuing ends in accordance with their fundamental beliefs and values.

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18 The split in the policy community/network literature is partly a function of the structure versus agency debate. Rhodes held that knowledge claims, preferences and choices for social action are much more closely bound up with an actor’s context than Wilks allowed for. Wilks and Wright were agency-oriented. A “rational actor” model that treats ideas and preferences as choices led them to depict policy making as more open, fluid and fragmented than the determinist model associated with Marsh and Rhodes (1992) and Smith (1993). As Rhodes later put it, contrasting his own work with the methodologically individualist American literature, “he [Rhodes] emphasizes the structural relationship between political institutions as the crucial element in a policy network, rather than the interpersonal relations between individuals within those institutions” (Rhodes, 1997; p. 36).
The knowledge-oriented version, both in Wilks' and Sabatier's formulation, is attractive to researchers because ideas and their sponsors can be readily identified. Thus there is some promise for conventional quantitative empirical modeling. In contrast, the structuralist accounts, while elegant and theoretically powerful, are only suited to case study designs.

The downside of the drive to operationalize for empirical testing is the risk that the "community/network" project will collapse back into pluralism. As Atkinson and Coleman put it: community and network theory risk becoming "nothing more than minor variations on the dominant pluralist theme" (Atkinson and Coleman, 1992). In fact, the pluralist problem of giving an adequate account of power resurfaces in Wilks and Sabatier. Theory and method drive the conclusion that power is associated with participation in the visible policy arena. Smith (1993), however, argued that participation is meaningless if it is on the terms dictated by the dominant members of a policy community, and takes place within a framework of ideas that supports the interests of the core actors. This key point will be examined in more detail in the light of Sabatier's "advocacy coalition" model.

2.3 Major Assumptions and Limitations in the Policy Community Literature

Some major assumptions of the community/network approach are:

- policy domains are appropriate units of analysis
- state and society can be treated as analytically distinct
- the key resource is information and the dynamic of networks is information exchange.

The choice of unit of analysis is not without implications. There is no doubt that different policy sectors have distinctive styles of politics and policy making. But it does not follow that policy domains or policy sectors should be the units of analysis. Making them so precludes theorizing at a macro level of societal or international forces, and implicitly denies any claim that sectoral politics and policies are essentially constrained or determined by broader forces. Cross-sectional analysis, or even more strikingly, cross-national analysis, yields obvious differences that cannot be theorized at the meso level of analysis. Consequently, poorly defined residual variables like "policy style" and other non-theorized macro-variables are invoked, more often than not haphazardly.  

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19 For example, Boase (1996b) in her international comparison of health policy invokes "political culture" and "political socialization" to explain differences her network/community approach cannot theorize. Both concepts are pluralist and neither can be theorized coherently within the state-institutional model Boase is advancing.
Analytical distinctiveness of state and society are necessary in order to impute a relationship between them. Within the community/network project, a lot of effort has gone into postulating the conditions necessary for sectors of the state to act autonomously. Atkinson and Coleman (1989), for example, claim:

- the agency needs a clear conception of its role and strong political support
- the agency needs to be able to retain its distance between itself and its clients
- autonomy may be enhanced by law and regulations defining powers and relationships
- the agency’s autonomy will be increased commensurate with its capacity to generate its own information.

However, the distinction between state and society is difficult to sustain. State and society interpenetrate. There are no clear boundaries. Much of state action is through non-state agencies. Partly as a result, the strong state/weak state typology has not proven very useful, nor have related typologies such VanWaarden’s state and society dominated networks (VanWaarden, 1992; Howlett and Ramesh, 1995).\(^{20}\)

In sum, the assumptions have implications that drive the perspective back to its pluralist roots. The sectoral approach construes the state as a collection of arenas. This is particularly evident in theorists who are committed to a programme of empirical research, hence adopt a methodologically individualist analysis (e.g. Knoke, 1990). In this style of network analysis, the distinction between state and society disappears entirely, as it does in Sabatier’s work for similar reasons.\(^{21}\)

The information exchange assumption marks a return to a conception of power as resources. The “exchange” part of the formulation construes networks as markets. As an offshoot from economics, various “resource dependency” models treat the environment of an organization to be other competing organizations. Each of these organizations controls assets such as capital, knowledge and so on. Each organization has to interact with the others to secure the resources it requires (Crozier and Friedberg, 1980; Klijn, 1997).

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\(^{20}\) Stone (1988) argued (in a different context) that it is disingenuous to regard the market, structured as it is by law and regulations, as any less coercive than other forms of state legislation or regulation. State and market interpenetrate in capitalist societies. A claim that the market is a social mechanism and regulation is a state mechanism is an ideological, not a theoretical, claim. Likewise, labeling policy actors as state or societal may have ideological implications. Defining an area as a policy sector and attempting to establish policies by organizing actors within it is overtly political (Bovens and ‘t Hart, 1996).

\(^{21}\) Ironically, Rhodes’ recent reformulation reduced his position to a pluralist one. “We define the core executive functionally to include all those organizations and structures which primarily serve to pool together and integrate central government policies, or act as final arbiters within the executive of conflicts between different elements of the government machine (Dunleavy and Rhodes, 1990; p. 4; cited in Rhodes, 1997, p. 14). This is clearly recognizable as the classic pluralist “brokerage function” of the state.
The focus on resource exchange takes no account of the meanings the interactions hold for the actors, nor of the norms that structure the preferences and strategies that undergird them. Rather, the account is strictly in terms of power as resources exercised in accordance with actors’ preferences. In short, pluralist public choice analysis and network analysis converge.

Empiricist network analysis construes the modern state as a highly fragmented entity, a collection of networks. That makes it difficult to explain why modern capitalist states are so much alike, their policy problems and responses so similar, and why there is an international convergence of governing instruments across developed capitalist states (Salamon, 1989).

Finally, it is unclear how much the policy community/network model actually adds to simple interest group models that treat policy development as the product of power struggles. Dowding, for example, argued there is very little “value-added”. The policy community/network approach is, according to Dowding, more a metaphor than a model (Dowding, 1995).

2.4 Neo-Institutionalism

Before considering ideas-based accounts of policy and policy change, attention needs to be paid to the major alternative to policy community theory that has appeared in the policy literature since the early-1980’s. Typically also a sectoral approach, neo-institutionalism was pioneered by Nordlinger (1981), Skocpol (1984), March and Olsen (1989) and Steinmo and Thelen (1992). The core claim of neo-institutionalism is that policy will remain consistent with established institutional arrangements unless external forces move policy onto a new trajectory. This is the concept of “path dependency”.

A path-dependent sequence of political changes is one that is tied to previous decisions and existing institutions. In path dependency, structural forces dominate, therefore policy movement is likely to be incremental. Strong conjunctural forces will likely be required to move policy further away from the existing path and onto a new trajectory (Wilsford, 1994; p. 252).

The underlying idea is that established political and institutional structures limit the range of policy options policy makers are likely to consider. This happens for several reasons. First, institutions support familiar casts of mind. Second, institutions embed a particular distribution of benefits and institutional leaders are amongst the beneficiaries. Thirdly,

22 Boase (1996a) similarly complains of a “bewildering array of concepts” and the penchant for abstract theorizing. See also Jordon (1990) for an argument that the community/policy network approach offers nothing that is truly new.
23 In the area of health policy, the leading study was Immergut’s comparative case study (Immergut, 1992). See also Wilsford (1994) and Boase (1996a, b).
institutional actors “define and articulate their policy problems and solutions initially by utilizing the institutionalized scripts, cues, and routines that constitute their cognitive frameworks and empower them to act” (Campbell, 1998; p. 378).

According to neo-institutionalism, conjunctures must combine with structures that are strong enough to effect change. That is why “strong centralized state structures can sometimes lead, paradoxically, to greater departures from the established policy path. That is, wholly new trajectories are made more easily possible by strong structures” (ibid.; p. 265).

This position, unfortunately, rests on a serious confusion. It is not “strong structures” that matter so much as the determination of government and its strength relative to organized social forces. For example, B.C. accomplished next to nothing in terms of creating new health governance structures in the three years between 1993 and 1996, whereas the neighbouring province of Alberta imposed regional governance bodies within a matter of months. Constitutional, legal and programme histories were consistent between the two adjacent provinces. The obvious differences between the situations were:

- the size of the majority the government commanded in the legislature (bigger in Alberta, particularly after May 1996);
- the power of the unions and the medical profession (both were more entrenched in B.C.);
- the ideologies of the governing parties (rightist in Alberta; leftist in B.C.);
- the degree of congruence between the governing party’s health care ideology and prevailing health care arrangements (greater divergence in B.C.); and
- governance style (at least partly a reflection of the other variables).

The variables, while largely “structural”, are only partially “institutional”, and several are external to the state. Further, they are bound up with power and legitimacy rather than with governmental arrangements.

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24 "Conjunctures are fleeting comings together of a number of diverse elements into new, single combination” (ibid.; p. 257). For example, the federal Liberal party forming a minority government dependent on NDP support at the time (1963) when the Royal Commission was preparing its recommendations on a national health insurance programme could be described as a “conjuncture” that led to the federal medicare policy.

25 The problem lies with inadequately distinguishing between state and social institutions. Neo-institutionalists err by treating policy dynamics as being entirely internal to the former – state institutions. As Hoberg pointed out (Hoberg, 1996), Sabatier made the obverse error. Sabatier treated all dynamics as though they take place within social institutions. See supra. p. 34.
The neo-institutionalists misunderstand power and interests because they base their work on misleading comparisons between the (pluralist and capitalist) U.S. and (corporatist and welfarist) European states. They fall into the old trap of traditional political science. That is, they attribute differences to constitutions and state forms that are merely cover for deeper power relationships.

"Neo-institutionalism" is useful in so far as it emphasizes that past policy and institutions shape future policy options. The underlying mechanism, the distribution of benefits and burdens by functioning institutions, is too thin an account, however. It does not connect interests to institutions or either to the exercise of power. The synthesis attempted later in this chapter clarifies power and interests with a view to constructing a fuller account of policy and policy change.

The importance of the attempted synthesis becomes evident in light of the findings in the primary case study. Those findings contradict the prevailing assumption in the literature that “the politics of health policy, like other public policies, is about resources awarded to some and withheld from others” (Wilsford, 1995; p. 572). The pluralist focus on the distributive question “to whom do the resources flow?” masks more interesting questions regarding the nature of institutions and the structure of beliefs in society. Health policy analysis, as this study shows, runs considerably deeper than the superficial dynamic of providers seeking more and states resisting them in that pursuit.

In the conventional view, “the cost of financing sophisticated health delivery systems pushes government and private insurers in every system, even in weak states and in fragmented decentralized systems, to diminish provider’s influence in making health policy” (ibid., p. 575). In this view, a state with many resources and the capacity to articulate a policy direction will prevail over (even highly organized) societal interests. One key state resource is control over the source of funds flowing to providers. Both pluralists and many health economists (who share the distributive perspective with pluralists) claim that sole source funding by the state is the most effective brake on health care expenditures (Reinhardt, 1978, 1994; Evans, 1996, 1997). A coherent state with a “single payer” health care system will prevail over providers and therefore achieve the presumed goal of welfare state health policy – an acceptable level of accessible health care at a relatively low, predictable cost. In this regard, the neo-institutionalist health policy literature frequently cites the putative contrast between the U.K. and Canada (strong states with single-payer mechanisms) and the United States (a weak state with a myriad of payment mechanisms).

There are serious difficulties with the claim that a single payer system makes for a strong state, a feature that in turn allows those states to dominate even highly organized sectoral interests such as medicine. First, the claim is vulnerable to circularity. The factors that limit costs of health care tend to be built into the definitions of the strong state. Second, those factors are subject to suspicious shifts in the literature. Boase and Wilsford invoke different factors when describing the strengths of different states. Federalism is, for example, a factor contributing to weakness in the case of the United States. However, it

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26 Boase (1996a and 1996b) and Wilsford (1995) are examples.
is construed as a source of strength in the case of Canada and Germany.\textsuperscript{27} The shifts are suspicious because strong states are identified in the first instance by their success. Thus Germany came through as a strong state because Wilsford judged the late 1980's and early 1990's (Blum and Seehofer) reforms to lower health care costs in Germany (\textit{ibid.}). The effects, while real, happened to coincide with a reduction in the rise of medical and drug costs throughout the OECD and, at least in the case of pharmaceuticals, have not proved sustainable. Likewise, the U.S. was deemed by Wilsford to be a weak state because its costs, at the time of his study, were still rising. However, subsequent data showed those U.S. costs were already beginning to moderate.\textsuperscript{28}

The pluralist model does not yield a satisfactory account of the Canadian situation either. According to Wilsford, “in Canada, high state autonomy confronts high interest mobilization and usually wins decisively” (\textit{ibid.} p. 594). He seems to have formed this view through exposure to the corpus of pluralist literature that (unfavourably) compared the U.S. health care system to the Canadian one combined with the publicity around the failed Ontario Medical Association strike. But to make out the distributive argument it must be shown that the state reduced providers’ incomes and not merely that fee schedule disputes have been won by the provincial authorities. That case has not been made. Further, even if provider incomes have been reduced by pressure exerted by the state, so what? Reductions in provider earnings from publicly funded medicare sources are not definitive evidence of the state gaining dominance over the medical profession. In purely pluralist terms, the physicians may have decided to trade one resource (income) for a more valuable one (clinical autonomy or freedom of choice of field or place of practice).\textsuperscript{29} In short, the broader pattern of resource allocation, and the choice field of the actors would require close analysis – another piece of work that remains undone by the pluralist health policy theorists. More fundamentally, core prerogatives such as dominance over other providers, exclusivity of practice, peer control over entry into the profession and exercise of privileges, as well as capacity to control the use of health care resources may all be unimpaired by downward pressure on earning capacity.

In short, pluralist analysis too readily finds that physician influence has waned. That is because it ignores the broader context. This study of the B.C. health care reform process makes it evident that the nature of the health care system, its history and the place of the institutional actors who have dominated it are important elements in an adequate

\textsuperscript{27} Gray (1991) develops a persuasive argument to the effect that no meaningful inferences regarding health care policy can be drawn from the institution of federalism. In some contexts, federalism may foster health policy innovation; in other contexts it may inhibit change.

\textsuperscript{28} See the debate between Henke, Murray and Ade (1994) and Reinhardt (1994) on single-payer financing and the differences between the German and U.S. health care systems. While conventional opinion held that single payer OECD countries constrained costs more effectively than other state financing systems, Abel-Smith (1994) found that it was the state’s power \textit{vis a vis} organized interests, not the nature of financing arrangements, that made the difference. It may be that a single payer system contributes to a state’s capacity (\textit{i.e.} power), but is not a decisive variable.

\textsuperscript{29} Even in “single payer” systems like Canada, physicians have, to some degree, engaged in income replacement strategies involving non-medicare billings. In the B.C. case, the Insurance Corporation of B.C. (automobile accident claims) and Workers’ Compensation are alternative sources of income. Some specialists (\textit{e.g.} dermatologists and ophthalmologists) concentrate on lucrative uninsured (\textit{i.e.} non-medically necessary) services. Others develop side-lines in “gray zones” (such as allergy testing).
understanding of health care policy dynamics. Policy analysis cannot be reduced, without serious distortion, to the state’s capacity defined in terms of institutional arrangements. Rather, attention must be paid to the broader array of interests and ideas that are entrenched in social institutions.

2.5 Ideas and Policy Change

Sabatier (1987) recognized the lack of research leverage provided by the policy community literature. He attempted to construct a simple model based on values and beliefs. The model assumes that the guiding principle in policy choice is a hierarchy of beliefs and values. Sets of value priorities are linked to causal assumptions regarding the means to reach those priorities. Activity goes on in a policy subsystem comprised of a wide variety of actors involved in the dissemination of ideas and information. Some are latent actors; others are active members of an “advocacy coalition”.

An “advocacy coalition” consists of “people from a variety of positions . . . who share a particular belief system - that is, a set of basic values, causal assumptions, and problem perceptions - and who show a non-trivial degree of coordinated activity over time” (Sabatier, 1993; p. 25).

Policy sub-systems will contain more than one advocacy coalition, each with its own belief system. Normally one of those coalitions dominates relevant state agencies and societal actors. Policy will reflect the dominant beliefs and values.

The “normal situation” is not, however, static. Some “policy learning” goes on within the coalition. “Coalitions seek to learn about how the world operates and the effects of various governmental interventions in order to realize their goals over time” (Jenkins-Smith and Sabatier, 1993; p.5). Coalitions learn from their efforts to impose their views. They re-orient their ideas and strategies in light of their interactions with opponents.

Sabatier postulates levels of beliefs - two levels in some of his formulations, three in others. The basic idea is that coalitions are founded on, and defined by, basic core beliefs, which Sabatier treats as analogous to a religion - stable and firmly held. They also have secondary beliefs that are instrumental in character. These beliefs are more fluid and change over time as a result of learning. “Evidence for one or another policy position may never challenge deeply entrenched beliefs, but it can force adjustment of the secondary aspects of belief systems” (Sabatier, 1987). The general idea is that policy ideas become more carefully honed and policy better informed as a consequence of conflicts between groups.30

30 This claim is interesting on several grounds. It freights a lot of liberal baggage regarding the merits of competition, free speech and free association and is strikingly reminiscent of John Stuart Mill’s argument in “On Liberty” (Mill, 1859). It also assumes an objectivist epistemology and an objective concept of interest. Sabatier provides no theoretical grounding for either.
Within governmental agencies, characteristics of the organization such as rate of turnover and recruitment patterns can facilitate or impede policy learning. Within coalitions more broadly, how open or closed they are to outside sources of information and expertise determines rate of learning. The picture emerging is a series of continuous, disjointed, policy adjustments, which leave the basic goals and beliefs intact.

Sabatier’s project throws up two huge challenges. First, how can an account be given for substantive policy change when policy is dominated by an entrenched set of actors clinging to their fundamental beliefs? Second, how can the relationship between core and secondary beliefs be theorized?

Sabatier advances five hypotheses in this regard:

1. the line-up of allies and opponents within a policy sub-system will be stable over periods of a decade or so;
2. actors within an advocacy coalition will show consensus on core beliefs, but less on secondary beliefs;
3. actors and coalitions will abandon secondary aspects of belief systems before acknowledging weakness in their core beliefs;
4. policies and programs will not be substantially revised as long as the coalition remains dominant;
5. the core of a governmental program will not change without “external perturbation”.

Intuitively, the hypotheses make sense. However, they are very difficult to operationalize. First, without some significant conceptual clarification, the advocacy coalitions cannot be identified. They are typed by their core beliefs, but how can those beliefs be identified? Expressed alternatively, how can beliefs be sorted a priori into core and secondary ones? Put yet another way, there is a real risk of circularity running through the first three hypotheses. Four and five, as stated without further conceptual clarification and operationalization, are circular in their own right. For example, it is only through the existence of a stable set of policy beliefs that we can infer the existence of a stable coalition.

31 The core and secondary beliefs problem is a variant of a long-standing issue in pluralist theory. For classical pluralism, the beliefs expressed through the concepts of political culture and public opinion are central to political analysis (Truman, 1951). A values and ideational based theory must postulate key beliefs as firm, almost immutable, or they would not be worth studying as the determinants of policy. Yet there must be a way to account for how they change. The attempted solution lies in defining political culture as deep, persisting beliefs, and public opinion as more ephemeral. The relationship between the “weather” of public opinion and the “climate” of political culture explains policy change. Unfortunately, there has been no satisfactory account of the relationship between political culture and public opinion. How they both change, and relate to policy change, remained problematic. Alford and Friedland discussed the intractability of this problem in *Powers of Theory* (Alford and Friedland, 1985).
Sabatier made an accurate, albeit banal claim, that groups have knowledge about how alternatives are perceived by their members and which alternatives are more practicable from the perspective of their constituency. And he was right to assert that expert knowledge might affect thinking about policy. But in the absence of a theory linking knowledge, interests and power, there is no basis for the further assumption that knowledge and learning cause policy change.

Sabatier held that interaction brings about learning and learning leads to more effective policy. Why, however, will the direction of change be necessarily towards more effective policy given that there is ample evidence that groups use ideas selectively and strategically? (Stone, 1988; Majone, 1989). Sabatier offers no reasons why interaction within a policy community should lead to learning but “external events” do not. This is counter-intuitive given that policy failures, especially disasters, may be effective catalysts for policy learning (Bovens and ‘t Hart, 1996). Finally, why and how is it that external events affect the “core”? For example, in which direction (if at all) will a collapse in international commodity prices affect a group’s deep values regarding the proper sphere of state activity?

The aforementioned difficulties led some researchers applying Sabatier’s framework to dodge the issue of specifying the variables and their relationship to policy learning, and to treat policy learning as though it is policy change. Hoberg (1996a) does not charge Sabatier himself with this offense, but he points to examples of others using Sabatier’s framework conflating policy-oriented learning with the process of policy change. Conflation is understandable, given the undertheorization of relationships and poor specification of variables.

Sabatier was well aware that the typology of beliefs is problematic, as evidenced by the amendments he made to the number of categories and their definitions. He struggled with the significance of resistance to change and how it can be operationalized. In the end, he failed because the theoretical linkages are missing from the alleged relationship between resistance to change, the actual content of beliefs, and the role of those beliefs in decision making.

Sabatier’s methodological suggestion to allow actors to indicate their belief systems via questionnaires and content analyses of documents and then empirically examine the extent to which these change over time (Sabatier 1993; p. 28) is unpromising. It is methodologically unsound to determine an actor’s belief system by asking him. Even if that objection was waived, how can the “stable core” be distilled from a belief system? If that stable core could be identified, what would it explain in terms of coalition building? Effective coalitions often include people who obviously share very little in terms of beliefs, core or otherwise. For example, health care unions, the elderly and municipal politicians may form citizens’ coalitions around health care issues only because each has a vested interest in preventing hospital closures. If Sabatier’s point was that long-standing, institutionalized groups have stable beliefs and values, in contradistinction to more transient pressure groups, he was right. However, the point relates to the influence
of roles, relationships and organizations on actors, not why actors join and act through coalitions (Pross, 1986).

The key assumption that coalition identity and stability stem from stable beliefs begs the questions: “From whence the content of these beliefs? and “What are the forces contributing to their stability?” The answer offered in the Rhodes’ policy community formulation reviewed earlier - viz. beliefs and norms are to be understood in the context of structural relationships grounded in economic and organizational interests - is plausible. But Sabatier explicitly rejected it on the grounds that beliefs must be the foundation for policy research (Sabatier, 1993; p. 28). That follows from methodological considerations, specifically Sabatier’s interest in pursuing empirical survey and questionnaire research. That approach smuggles in the pluralist assumption that statements about the beliefs and interests of groups are statements about individual actors.

The method abstracts away the context in which the actors are situated. “By ignoring [the meaningful social and political relationships in which their attitudes and actions are embedded], surveys threaten to reduce social science to ‘aggregate psychology’” (Knoke, 1990, p.33). Aggregate psychology is incompatible with the view that beliefs and interests are (at least partly) endogenous to institutions. It is also incompatible with a structural position on power, or to put it otherwise, with the role of ideology. Hoberg (1996) cogently argued “key concepts such as learning, advocacy coalitions, and policy change, are poorly specified and the causal relations between them are unclear”. The promised alternative to power and interest-based theories does not materialize. Hoberg also pointed out that Sabatier deliberately departed from distinguishing between state and societal actors. All are lumped together based on shared beliefs. That has the advantage of highlighting the commonalities amongst the actors, but misses the important point “that some people have authority to make policy and other people do not” (Hoberg, 1996, p.138).

Hoberg noted that Sabatier, like the classical pluralists, assumed a policy brokerage function. The point is fundamental: “Conceptually, core policy makers cannot be both members of advocacy coalitions and play the third-party role of brokering between coalitions. Their [Sabatier’s and Jenkins’] framework obscures and confuses the relevant distinctions between state and non-state actors in the policy process” (Hoberg, 1996; p 138). This is the heart of the problem with all pluralist accounts - they misrepresent fundamental issues of power and legitimacy.

32 “[Coalition] stability could be the result not of stable beliefs but rather of stable economic and organizational interests” (Sabatier, 1993; p. 28).
33 Atkinson and Coleman (1992) argued that accounts like Sabatier’s are limited, partial and misleading because they lack a concept of ideology. They are mistaken, however, in thinking the framework can be modified by simply including an ideological dimension. The implication of the foregoing discussion is an ideological dimension requires a different theoretical foundation. That foundation will be further explicated later in the chapter.
Parsens (1995) raised a related question about power. Are successful advocacy coalitions those that learn better than others or simply those that have more power? Sabatier made the important point that policy ideas change through a learning process, but he did so at the risk of downplaying how policy ideas reflect fundamental interests. In Parsen’s view, the whole conception of “policy-oriented learning” is fraught since it imports “empirical truth” into a realm that is inherently interpretative and strategic.

2.6 Establishing the Context of Social Action

Sabatier’s effort to ground policy research on beliefs and values carries over the principal weakness of rational actor models in general and pluralism in particular. Both assume agents are pursuing their preferences in accordance with propositions they hold about the world. Agency models fail to situate the actors in the context of their ongoing relationships, whether the reference is to actors within their own organization, or to organizations as actors within coalitions, networks or policy communities.

Many network theorists (e.g. Laumann and Knoke, 1987; Hall, 1993; Klijn, 1996) argue that analysis must be sensitive to the context in which actors are embedded. That typically means analyzing communications, socialization and sanctioning processes. It also means incorporating past relations, possibilities for learning, opportunities and constraints through adopting what Knoke calls a “structural” approach.  

\[ Structural \text{ analysis can reveal how interpersonal networks shape actors' } \]
\[ \text{perceptions of political objects, how mutual interactions generate shared imputed meanings, how actors construe the possibilities of choosing amongst alternative actions, and how subjective beliefs arise that link personal action to collective outcomes. (Knoke, 1990, p.26) } \]

34 What is meant by “structural”, however, varies. That variability is an important source of confusion. “Structural” in the European literature typically means “informed by the institutional context”. “Structural” in the American literature means “influenced by the institutional context”. The latter involves inclusion of institutional variables; the former involves trying to understand how social structures shape meanings, perceptions, and the ability to conceive of choices for action. This is another face of the “structure/agency” problem discussed earlier.
Sensitivity to context and linking individual action to collective outcomes does not, however, forge the link between interests and ideas. The difficulty bedeviling Sabatier's model, the lack of a bridge between beliefs and values on the one side and interests on the other, replicates itself in the network literature due to the underlying empiricism in both accounts. Knoke, for example, took an explicitly behaviourist position. He sought to learn how networks constrain and socialize their members to certain patterns of thought and action. What cannot be disclosed from that theoretical perspective is how institutions including networks constrain the understanding of actors, the meanings they attribute to their involvement. Knoke's sense of "shared imputed meanings" is psychological, not linguistic or cognitive. It does not represent the usual, less idiosyncratic, meaning of "structural" - how social institutions shape not only behaviours by systems of incentives and sanctions, but more fundamentally, how they shape the frames of reference of their members. A structural account in that sense is an account of ideology. Only such a structural account can bridge between ideas and interests.

Network analysis shows how institutional contexts constrain information exchange, includes influences from others with whom an agent interacts, and partially explains the patterned responses from groups that are involved in regular exchanges. For example, a network analysis could undertake to explain, in the context of an observation that Canadian physicians are more conservative in their treatment of patients than American ones, but less conservative than British doctors, why there are conservative and aggressive outliers. The proposition drawn from network theory is that aggressive or highly conservative practitioners belong to sub-networks of like-minded doctors. That is, a conservative Canadian practitioner belongs to a sub-network closer in its norms to a British medical network; an aggressive Canadian practitioner belongs to a sub-network more akin to an American medical network.

But more fundamental than behavioural norms is the way the actors perceive issues and relative positions. Ideational structures, "world views" or "frames of reference" define for actors what is important and meaningful. Those frames of reference cannot be identified through a study of institutional constraints and behavioural norms.

In other words, it is not only true that conservative patterns of practice are reinforced through belonging to a group of conservative practitioners. It is also true that the understanding of the role and meaning of medical intervention, the relationship between patient and practitioner, the meaning and degree of aversion to risk, etc., may be

35 Sabatier appears unaware of the lack of linkage in his analysis. This is probably due to conflating ideas with interests by trading on the ambiguity of the word "interest". That is, sharing beliefs and preferences means "sharing an interest in", but that is not the same thing as "interests" in the sense of identifying and pursuing something that is wanted or needed. For example, a disease self-help group may share an interest in a particular health condition but it will not be an interest group unless it lobbies for services or special dispensation.

36 An important practical proposition follows from the analysis. If health care managers want to influence patterns of practice, they need to influence the sub-networks in which doctors practice. The analysis suggests that targeting opinion leaders within a cluster of medical practitioners might be a more effective strategy than attempting to sway practice through general educational approaches. See Mansfield (1995) and Oxman et.al. (1995).
conceived of differently by members of different institutional groupings. By implication, a complete analysis would need to look at the incentives embedded in a set of organizational arrangements, the nature of the ideas informing those arrangements, and the relationship between the ideas and the distribution of benefits and burdens.

2.7 Power and Interests

The pluralist view of power is associated with the work of Robert Dahl (1961). The focus is on behaviour in the making of decisions on public issues in the context of discernable conflict of subjective interests (i.e. preferences). Interests are revealed by political participation, joining specific interest groups. Power is resource-based - i.e. is reducible to the mobilization of resources.

An organizational view of power is associated with the work of Bachrach and Baratz (1962). They agreed with Dahl that power was exercised whenever actor A got actor B to do something B would not otherwise do. But they also claimed: "power is also exercised when A devotes his energies to creating and reinforcing social and political values and institutional practices that limit the scope of the political process to public consideration of only those issues which are comparatively innocuous to A" (Bachrach and Baratz, 1962: p.7).

Bachrach and Baratz adopted Schattschneider's aphorism "all forms of political organization have a bias in favour of the exploitation of some kinds of conflict and the suppression of others, because organization is the mobilization of bias" (Schattschneider, 1960: p. 71, emphasis in original).

Policy framing may be strategic (Stone, 1988). An organization may be more concerned with conveying a message to others, reducing pressure surrounding an issue, establishing boundaries, managing the change process, or simply masking its true position, rather than the purported goals. An organization may intend to pursue quite different goals at a later stage in the policy process.  

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37 The Canadian federal government’s role in health policy demonstrates both the symbolic and strategic dimensions of policy framing. The Lalonde Report (1974), which argued that health determinants such as environmental factors and lifestyles were much more important for the public’s health than medical services, presaged federal termination of open ended funding of provincial medical and hospital insurance plans and its replacement with formula-driven payments (“EPF”). As the federal government reduced the proportion of health care expenses it covered through transfer payments to the provinces, it increased its own visibility through extensive health promotional advertising. In a like fashion, the rhetoric preceding the Canada Health Act, and the principles elucidated in its preamble, bore no relation to the actual content of the legislation (dollar for dollar cuts in funding to provinces which permitted private medical billing in excess of insured amounts). Prior to the next major round of federal cuts in health spending, the federal Minister of Health released another report impugning the significance of medical and hospital services (Epp, 1986). The federal government simultaneously claimed “the high road” and cut its spending.
Institutional procedures and processes include some actors, support some perspectives, and exclude or suppress others. They systematically lend support to some (dominant) actors' interests and systematically thwart the interests of challengers. Analysis of policy making and implementation cannot focus only on conflict and participation (pace Dahl), because many potential issues and actors have no voice. "Non-decisions" are as important as decisions. Interests, in the organizational account, are construed as subjective policy preferences, but they are highly constrained by institutional factors and may be hidden from other parties. Organizational forms, patterns of interaction and fundamental beliefs operate in support of the interests of the powerful.

Steven Lukes, in a provocative essay (Lukes, 1974), argued that the processes that shape actors' perceptions of their (subjective) interests are themselves a form of power. Institutional processes affect an actor's (objective) interests, although the actor may be unaware of it. The analysis parallels the Marxist notion of false consciousness. That is, social structures may shape the thinking of an actor to such a degree that the actor cannot identify his/her own best or real interests. The classic Marxist claim in this regard is that market economies operate in such a way that people are forced to regard their own labour as a commodity and economic exchanges and tradeoffs as appropriate modes of human interaction. People are thereby blinded to social possibilities for alternative means of interaction.

Both the idea of "objective" or "real" interests and the concept of false consciousness remain mired in controversy. That controversy has encouraged many to step back from an explicitly ideological level of analysis and treat "real" or "objective" interests as merely the explicitly identifiable costs and benefits accruing to actors as a consequence of the operation of social institutions. Saunders, for example, claimed real interests exist and differ from the expressed preferences of actors. They are to be found by examining the resource distributions associated with the institutions supported by the various actors (Saunders, 1980). The approach has a wide following in the literature (for example, Evans, 1997a).

However, the attribution of objective interests remains problematic.

*Even if we can show that a given status quo benefits some people disproportionately, such a demonstration falls short of showing that these beneficiaries created the status quo, act in any meaningful way to maintain it, or could, in the future, act effectively to deter changes in it* (Polsby, 1980, p. 208).38

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38 This is one of the reasons why it is important to know what the actors believe and how those beliefs relate to the distributions of benefits and burdens. It is a mistake to reduce policy analysis to the pursuit of interests narrowly defined. Actors are partly governed by norms and values. Parties in the health field are, in addition to pursing narrow material interests, advancing their own conception of what the health system should be like, who it should serve, and who should be entitled to make what sorts of decisions. Those conceptions are not reducible to, though they are often congruent with, material interests. Further, the underlying view of rationality which restricts rationality to instrumental action out of self-interest is indefensible (see, for example, Jachtenfuchs, 1996; p. 9). Therefore, an analysis limited to purely distributional effects, while simple and elegant, is also limited and potentially misleading. However, it remains true that espoused beliefs and values may be only rhetoric serving as cover for narrow interests or
Parting company with Lukes and Saunders, post-modernists argued the idea of objective or real interests is a delusion. Critical theorists such as Habermas (1972) and post-modernists such as Foucault (1970) agreed with Lukes that the social construction of a system of beliefs and knowledge claims is a function of power. However, they disputed the possibility of any context-free interpretation. The implication is that all forms of social organization embed power relations as well as define the interests being served.

The post-modernist linkage of knowledge with power and legitimacy makes intuitive sense. Power centres such as unions, professional bodies and employer associations not only use knowledge strategically, but also attempt to create their own knowledge bases and their own rules of evidence and validation (Pal, 1990). They advance claims regarding their own legitimacy, and on their own, through coalitions or in partnership with state actors, construct hybrid advocacy-research agencies. Professions are excellent examples. Nursing, as a case in point, claims its own knowledge domain, its own research strategies, its legitimacy as “the caring profession”, indeed a whole “critical paradigm” defined in good part in opposition to a “medical model” which nursing also constructed as a foil. Similarly, the British Columbia Medical Association and the British Columbia Nurses’ Union spar over which profession has the relevant expertise, should have the lead role in, and be paid for, preventive health services such as patient counseling. Likewise in the troubled 1998/99 period, both the medical and the nursing unions claimed their respective job actions were designed to protect medicare and the health of the public while each criticized the other for acting out of self-interest. These cases illustrate the interrelationship among interests, claims to knowledge, power and legitimacy within and across health professions.

Specific language forms, styled “discourses” by Foucault and “network dialects” by network theorists, can arise and dominate the thinking of an organized actor or network. They incorporate power dimensions by facilitating thought and action in certain directions and precluding it in others. They have disciplining effects, requiring actors who wish to be heard in policy formation and implementation to obey the rules of that discourse. Failure to follow the rules of the discourse makes an attempted contribution appear irrelevant or incongruous. Following the rules constrains what can be said.

Post-modernism substitutes a plurality of socially constructed subjective interests for personal preferences or objectively defined interests. It dodges the false consciousness bullet, but does so at the risk of relativism. Everything ends up from a perspective, a unique context. There is no remaining Archimedean point upon which to lever analysis. Public policy making reduces to “neo-tribes talking past one another in a game typified by symbolic politics and competition for meaning, not material goods” (Rhodes, 1997; p. 185).

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as disguises of distributional effects. It is important to explore both ideational and material dimensions in their contexts.
The more trenchant critics of pluralism and certainly the post-modernists have shown that the traditional empiricist approaches to public policy are limited to the point of being unrealistic or irrelevant. Traditional approaches ignore or misrepresent significant dimensions of power. They inappropriately abstract knowledge from interests and power, as well as abstract actors from their contexts. However, the alternative risks collapsing into “perspective truths”. Post-modern interpretive analysis “may allow us to spot inconsistencies and metaphors, it does not allow us to reveal the interests and power structures” (Thompson, 1993, p. 197) that underlie public policy.

2.8 Structural Interests, Networks and Policy Communities

Between the 1970’s, when Alford (1975) argued that the health sector was dominated by the “structural interest” of organized medicine, and the 1990’s, the position of policy theorists has changed substantially. The 1970’s debate between pluralists who contended that a variety of interest groups could mobilize to exert countervailing power over entrenched interests and structuralists who argued that a deeper and more profound power was exerted through organizational and ideological mechanisms has been subsumed by the policy network literature.

The principal feature distinguishing policy networks and communities from pluralist clusters and dominant interests is the state’s role in fostering and managing the network of actors who comprise a given policy field. As Jordon and Richardson put it, contemporary democratic capitalist governments have an interest in facilitating a consultative style of government, reducing policy conflict, depoliticizing sensitive issues, making policy implementation predictable, and segmenting their activities along departmental lines (Jordon and Richardson, 1987). Power and legitimacy are also bound up in the relationship between state actors and societal ones. “Group power depends on state recognition and state power depends on the support of groups” (Smith, 1993, p. 6).

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39 The whole enterprise of modeling politics and policy on bargaining, games theory and micro-economic constructs collapses if interests are unstable. In other words, interests of the parties must be assumed to be exogenous and fixed, because if parties’ interests shift as a result of interaction, bargaining would be confounded. It has been shown that goals in bargaining do shift through the process (Wheeler, 1993). However, if the parties to bargaining re-conceive of their interests, they may find themselves disconnected from the constituencies and organizations they represent. They have gone through not a bargaining process but a conversion process.
Partly due to increasing policy complexity, partly due to fragmentation in society, partly
due to the post-1973 crisis of governmental legitimacy, policy came to be increasingly
managed through networks. Allegedly, in consequence, systems of resource
interdependencies have displaced dominant structural interests. (Pal, 1997; Sabatier,
1993).

Some analysts were so rash as to proclaim the demise of structural interests.

*The result of this reorganized coalition landscape is a new distribution of power
which is no longer dominated by the medical profession or stable “structural”
colleations but rather by unstable “action sets” in which organized interests have
formed a temporary alliance for a limited purpose.* (Dohler, 1991, p. 269)

But Dohler’s claim is significantly at odds with Martin Smith’s interpretation. Smith
held that policy communities institutionalize a prevailing distribution of power and a
particular perspective on the policy sector (Smith, 1993). Smith was able to sustain that
claim because he, like Alford before him, carefully distinguished between transient
pluralist networks, integrated organizational networks, and deeply rooted policy
communities. Unlike Dohler, Smith recognized the importance of different levels of
analysis and therefore avoided conflating them.

The distinction between three levels of analysis – one suited to networks where pressure
groups struggle to influence policy, another to bureaucratic formations, and a third to
organizational forms reflecting deeply held views – was made by Alford and Friedland
(1985). The first level is the strategic actor level. Actors have conscious preferences and
sets of beliefs about how to attain them. Those beliefs include beliefs about institutions
and networks, for example roles and reputational power. Incentives and sanctions are
part of the strategic decision making field. Appropriate research methods are
quantitative, behavioural methods such as surveys.

The second level is the organizational level. Contextual constraints such as restrictive
entry, established norms, operating procedures, socialization, and embedded incentives
and sanctions, shape beliefs. There may be a distinct cultural orientation influencing the
selection, definition of, and response to, policy issues (Thompson, Ellis and Wildavsky,
1990). Appropriate research methods are by-and-large qualitative.

The third level is the structural, ideological level. It is comprised of fundamental
cognitive organizing principles that structure understanding and action. Patterned social
interaction (“institutions”) is the source of those principles. Those institutions “shape
understandings, preferences and interests as well as the repertoire of behaviours by which

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40 For the crisis of government legitimacy, see Offe (1984) for a Marxist interpretation, Habermas (1976)
for a critical theory perspective, and Poggi (1990) and Ham and Hill (1993) for an analysis of the
relationships amongst legitimacy, taxation and the welfare state.

41 “Social relations are sustained by generating preferences that in turn reproduce those social relations”
(Thompson, Ellis and Wildavsky, 1990, p. 66). Preferences are influenced or shaped by organizational
context; however, they are still assumed to be (at least partly) exogenous.
those preferences and interests are attained” (Friedland and Alford, 1991: p. 232).
Appropriate research methods are exclusively qualitative ones that deal explicitly with
the attribution of meaning and reasons for action.

The typology suggests an attractive approach to the analysis of public policy. Each
theoretical perspective can be used as a “lens” to bring into focus different perceptions
and alternative explanations of the policy process. Allison (1971) pioneered such an
approach in his study of the 1962 Cuban missile crisis.

Dunleavy (Dunleavy, 1991) is a contemporary advocate of theoretical “lenses”. He
argued a multi-model analysis yields sets of parallel hypotheses that can be tested to
determine which theoretical lens gives the most powerful account of a phenomenon.
While intuitively appealing, the method is unsatisfactory. Since the hypotheses are
derived from different theoretical perspectives, address different levels of analysis, and
require different research strategies, testing must be informed by a meta-theory. But it is
precisely the absence of overarching theory that makes multi-modeling necessary. In
short, the approach begs the question.

The multiple lens approach also ignores the reality that data collection is theory driven.
No data set can be unproblematically applied across disparate theoretical propositions.
Applying multiple lenses raises serious problems of theory building and coherence. With
that observation in mind, the remainder of the chapter will be devoted to examining the
prospects for a structural theoretical synthesis.

2.9 Policy as Ideology

Martin Smith (1993) argued that the key to understanding policy outcomes is the
ideology informing institutional structures and networks. That is true in part because
“policy is limited to what is acceptable to the consensus within the policy community”
(Smith, 1993; p. 71). Elsewhere, Smith said:

*Ideology defines not only what policy options are available but what problems
exist. In other words, it defines the agenda of issues with which the policy
community has to deal. Therefore members of a policy community agree on both
the range of the existing problems and the potential solutions to these problems*
(Smith, 1993; p. 62).

The problem of the bridge between ideas and interests can be solved by conceiving of
policy as ideology (Stone, 1988; Smith, 1993), rather than as propositions about the
world and actors’ preferences (Sabatier). A policy-as-ideology perspective allows
several key connections to be made. First, the reformulation recognizes policy is
redistributive in its effects. Interests are engaged because some parties will gain
positionally *vis-a-vis* others as a consequence of any policy change. There is no such
thing as a neutral policy, and policy implementation is inherently value-laden. Second, the reformulation links theoretically the concept of interests with the pursuit of policy goals. It does so while recognizing Sabatier’s insight that ideas very much matter, and learning is an important part of policy implementation. Thirdly, the reformulation suggests a more productive research agenda than Sabatier’s or the network theorists.

Specifically, it suggests examining the ideological content of positions to determine:

- how actors frame issues;
- the distributive implications of how the issues are framed; and
- how the framing of issues sets limits.

Dynamically, a policy-as-ideology perspective suggests focusing on how the framing process and the policy content change as a result of the interaction of actors within a policy community.

An influential approach to policy-as-ideology was developed by Peter Hall (Hall, 1993). He made the point that the policy process takes place within a discourse. Ideas, values and goals must be perceived by the relevant actors to be comprehensible and plausible.

Hall did not infer that meanings determine actions. But meanings do render some options conceivable or inconceivable, acceptable or unacceptable (Yee, 1996; p. 95).

> Policy makers customarily 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 (Hall, 1993; p. 279).

Hall, following Kuhn (Kuhn, 1962), called the framework of ideas a “paradigm”. Because fundamental assumptions and values differ, it is not possible to muster evidence demonstrating the superiority of one paradigm over another. The evidence itself will be interpreted differently by actors whose frames of reference fundamentally diverge.

Hall derived four important conclusions from the idea that policy in a given sector will be informed by a paradigm. First, Sabatier was wrong to assume a large role for a learning process informed by a growing appreciation of the facts. Policy change is more a political process than an epistemological one. The relevant variables are positional advantage in the prevailing institutional framework, command of resources, and exogenous developments contributing to the power of the actors associated with a given perspective.
Second, since some policy disputes involve irreconcilable perspectives, politicians must choose which one is authoritative. That choice confers legitimacy on the actors who promote the authoritative perspective. Policy change is fundamentally about authority and legitimacy, not truth.42

Third, decisive policy failure, or perhaps more accurately the perception that a policy has failed, is typically a necessary condition for abandonment of an entrenched, authoritative, perspective.

Fourth, the old perspective may well linger on or even return to dominance unless the purveyors of the new perspective succeed in institutionalizing their point of view. Ideas only exert power through finding organizational form (Hall, 1993; p. 281).43

Hall’s position was a reaction to both Sabatier who claimed elite opinion changes through policy-oriented learning and Baumgartner and Jones (1993) who claimed policy change reflects a “punctuated equilibrium”. Baumgartner and Jones, like Sabatier, sought to explain how a stable policy community dominated by a set of ideas held by a controlling elite might change. The solution they proposed lay in examining the processes that unsettle the way the policy field is understood and that thereby threaten the institutions built around that understanding. New policy means new institutions replacing the old and a return to a new equilibrium dominated by a new set of actors – the beneficiaries of the redistribution of resources that attends the institutional change.

Baumgartner and Jones’ model is a variant of pluralist countervailing power theory. Critics have pointed out that it seems to describe policy areas where policy change has little or no effect on deep structural interests – for example, smoking policy. New ideas are much less likely to rise to prominence and spawn new institutional forms where important institutional actors’ interests are adversely affected (Parsons, 1995, p. 207).

42 Traditional rational actor analysis, pluralist theory and public choice theory all “share the central idea of instrumental rationality: that policy makers are rational actors who chose the means – policy positions, strategies of political action, or negotiating ploys – that they believe to be best suited to the achievement of their ends” (Shon and Rein, 1993; p. 10). But such a view cannot account for intractable policy controversies “for if players of the political game are rational actors, why should some disputes prove stubbornly resistant to settlement by means of bargaining and exchange?” (ibid. p. 15). The answer lies, as Hall argued, in the fact that some policy disputes are about principles informing societal arrangements and not merely the distribution of benefits and burdens. As Kant pointed out two hundred years ago, principles regarding rights, obligations and powers (deontology) are irreconcilable with sets of outcomes (teleology). Principles cannot be reduced to outcomes and disputes that engage principles are different from disputes that effect distributions. Hall distinguished between “policy changes” that involved only instruments and their settings (distributive issues) and “policy reforms” that involved matters of principle. The latter cannot be bargained nor can a “common truth” be arrived at through mutual learning. Rather the outcome must be authoritatively determined. Similarly, Shon and Rein argued for a distinction between “policy disagreements” (which can be bargained) and “policy controversies” which cannot (ibid. p. 3).

43 Yee provides an explanation for Hall’s claim regarding the institutionalization of ideas: “... when ideas are embedded in institutions, these institutions facilitate the implementation of those ideas by giving them organizational support and a means of expression ... Institutions do more than simply supply organizational support to ideas. Institutions reflect a set of dominant ideas translated through legal mechanisms into formal government organizations” (Yee, 1996; p. 88).
Hall adapted the idea of punctuated equilibrium but took a more explicitly political position. Ideas, according to Hall, require political support. They must come to appeal to a constituency for change. In order to account for that constituency supporting change, Hall drew on the concept of “accumulated anomalies” (Kuhn, 1962).

Kuhn argued in his influential *Structure of Scientific Revolutions* (1962) that theory development in science is not an iterative process of developing more comprehensive theories in light of experience. Rather, a whole theoretical framework such as Newtonian physics is overthrown by a completely incompatible alternative such as Einsteinian physics. What can be said and understood in one framework — “paradigm” — cannot be said or understood in the other.

Kuhn claimed that a community of scholars rejects a paradigm when anomalies have accumulated to some critical threshold. Discoveries of internal inconsistencies and contrary findings eventually delegitimize the paradigm creating the conditions for the effective advocacy of an alternative. Hall adapted this idea to policy change.

Policy domains are typically dominated by an established policy paradigm. Over time, however, anomalies accumulate. Policy makers are compelled to experiment with a view to improving the “fit”. The policy field begins to fragment and the old paradigm undergoes delegitimation. Groups begin to contest policy alternatives. Finally a new paradigm emerges and becomes institutionalized (Hall, 1990).

Unfortunately, there are a number of serious problems with the underlying theory of ideational revolutions. First, Kuhn’s model initiates a retrospective hunt for “accumulated anomalies”. Those anomalies can, in principle, only be identified from the perspective of the new paradigm and the present moment in time. At the very least, findings are biased from importing the present paradigm into the past; at worst the approach begs the question.

Hall’s model also neglects organizational power variables. Alternative views or paradigms are typically in currency for considerable periods of time before they reach ascendancy. As Tesh (1988) pointed out, germ theory was espoused for a long time before it was finally adopted as a mainstream view. Paradoxically, evidence supporting germ theory was actually weaker at the time of its adoption than it was earlier, due to some heroic efforts to disprove it.

Ideas like germ theory become fashionable when they link with broader social trends, prove advantageous to powerful groups, serve key commercial interests, or come into alignment with other prevailing ideas and attitudes. “Anomalies”, accumulated or otherwise, are not decisive in the transformation of patterns of thought. Rather, Tesh

44 Howlett (1994) applied the heuristic to Canadian Indian Affairs policy, demonstrating that it has descriptive force (albeit with some issues regarding sequencing).
45 Hall’s model ignores symbolic, strategic and ideological dimensions of political discourse. See Campbell (1998; p. 381).
argued, attention should be paid to those with a material interest in the matter and the resources to effect a transformation in thinking and organization.\footnote{This is not to deny that actors might drift into a new understanding through a series of incremental adjustments. Such a drift is evident at the individual level. An individual’s outlook on life may profoundly shift in an unplanned way over time. Drift is unlikely to be profound in the case of institutional actors, however, since they are anchored in the dominant institutions.}

Hall’s model of policy change lacks explanatory force. That is primarily due to the conceptual problems inherent in the approach adopted from Kuhn. Nevertheless, Hall’s work is important because of the attention he drew to authority and legitimacy. He argued effectively for treating delegitimation of an old set of policy values and beliefs and effective institutionalization of the new one as necessary conditions for fundamental policy change. The problems with his model are fundamental enough, however, that it is wise to avoid entirely the fashionable Kuhnian term “paradigm”.

Following Shon and Rein (1994) this case study of British Columbia’s health care reform will refer to the structures of belief, perception and appreciation underlying policy positions as “frames” or “frames of reference”. Following Shon and Rein, Hall, and Termeer and Koppenjan (1997), intractable policy controversies such as those endemic to the health sector are assumed to exist where the frames held by the contending parties conflict. Reasoned argument and bargaining strategies fail because the parties rely on different evidence and interpretations of that evidence. Since those frames are institutionally and historically derived, they are generally beyond the consciousness of the actors. “The institutional context may carry its own characteristic perspectives and ways of framing issues, or it may offer particular roles, channels, and norms for discussion and debate” (Shon and Rein, 1994; p. 31).

Adopting a framing analysis moves the study into a position closely associated with post-modernism generally, and interpretative analysis more specifically. This case study attempts to avoid the threat of relativism by holding to a modified interpretative position grounded in the sensible assumptions that all knowledge about social affairs is based on partial information and social constructions.\footnote{“Constructivism does not deny the existence of a reality outside the observing actor. It is also neither anti-empirical nor merely concerned with mental processes, but merely argues that the world is only accessible to actors via cognition” (Jachtenfuchs, p. 19).} The question of subjective versus objective interests, like the underlying ontological questions about the nature of reality and how it might be known, is deliberately kept open.

Expressing this less abstractly, the study supports Termeer and Koppenjan’s position that “blockages in policy processes are not only caused by conflicts of interest and power relations, but equally by the perceptions of the actors involved” (Termeer & Koppenjan, 1997, p. 78). Policy analysis, as was argued at length earlier, should be based on the actors’ frames of reference.
Those frames of reference are amenable to empirical research and they include:

- ascribed meanings to the world around them
- values and norms
- a definition of the problem
- perceptions of the other actors in the network
- views on the nature and degree of dependency on others
- an assessment of the advantages and disadvantages of collaborative strategies.

Following Sabatier and Hall, the study assumes that most of the elements of frames of reference are stable and difficult to change.\textsuperscript{48} Actors pursue their interests as those are interpreted through their respective frames of reference. Networks typically have a dominant frame of reference. The more closed the network, the "tighter" the policy community, the greater the dominance of a frame of reference (Smith, 1993). Substantive policy change requires either substantive change in the network's dominant frame of reference, or, alternatively, external power sufficient to coerce or act independently of the network (Hall, 1993). Coercion or independent action is highly exceptional and likely short-lived, since the only candidate with sufficient autonomy and legitimacy is government. Modern democratic governments in advanced capitalist states manage policy through networks precisely because they lack the knowledge, power and legitimacy to do otherwise (Cawson, 1986; Jordan, 1990; Smith, 1993; Hall, 1993).\textsuperscript{49}

As was argued earlier in the chapter, a unified theoretical perspective needs to inform a study for the work to be coherent. From a theoretical perspective, a synthetic approach that recognizes the interrelationship between ideas as frames of reference and interests understood as material benefits offers the most power. It recognizes that frames and interests are logically independent, but also recognizes that frames shape interests (and the means to attain them). Further, it recognizes that frames may be used strategically to promote interests.

\textsuperscript{48} The assessment of advantages and disadvantages of various strategies is obviously strategic and most subject to change.
\textsuperscript{49} Sam Sheps (personal communication) suggested the paucity of knowledge and legitimacy of modern governments may be linked to the downsizing and politicization of the bureaucracy. The demise of bureaucracy as an expertise-based system that lent stability and predictability to public life is certainly part of advanced capitalism and post-modernism.
To ask whether either interests or ideas are the chief determinants of policy outcomes is a misleading way to pose the issue because it neglects the possibility that it is the interaction between the two that counts and that some types of ideas are endogenous to the policy process in the sense that they are influenced by policy struggles in which interests, resources, and power loom large. (Campbell, 1998, p. 379).

Acknowledging the institutional origin of frames, the approach avoids the misrepresentation of ideas, interests and power typical of the conventional literature. Importantly, it is also the correct approach to the subject in hand. The organization of the delivery of health care clearly involves deeply held beliefs and values, substantial material interests, and considerable rhetoric.

However obvious such an approach is, a structural-ideological study along the lines of the synthesis advanced here has been largely avoided in the North American literature because there appears to be no ready way to operationalize it. Most of the work to-date has been either highly theoretical or post-modernist – the former abstract without substantive content, the latter full of content but atheoretical. The goal of this study is to breathe real life into the perspective - to develop and apply an empirically informed theoretical approach to studying health policy as ideology, using British Columbia’s health reform initiative as a case study.50

Reliance on the expression “policy as ideology” is risky and bears explanation. The concept of ideology carries baggage from Marxist, anti-Marxist and post-modern sources. As used here, ideology means a frame of reference, the cognitive organizing principles structuring perceptions and allowing the interpretation of complex realities. As a frame of reference, it has both selective and regulatory effects - i.e. it selects in some aspects of reality as relevant and meaningful and rules out others as non-existent or meaningless.51

“Ideology” is closely related to Hall’s use of the term “paradigm”, although the unrealistic assumption that a paradigm can never be even partially translated into another is not carried over into the conceptualization.52 Importantly, though, the expression is intended to go beyond Hall and Shon and Rein by explicitly linking “frames” to

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50 The study is an empirically informed theoretical study and not a theoretically informed empirical study. Not enough progress has been made on the “conceptual, philosophical and theoretical side in order to develop a coherent and relevant framework amenable to empirical research” (Bovens and t’Hart, 1996, preface, iii).

51 Using terms like “reality” suggests both an epistemological and ontological position - viz. there is a single “reality” and it can be known, albeit through interpretations structured by frames of reference. Such a position would be anti-relativist and inconsistent with many post-modern “social construction of reality” theories. In fact, no position is being taken on these fundamental philosophical questions. For the sake of the proposed analysis, all that needs to be conceded is that an actor can only have access to views about reality through institutionally structured frames of reference. Whether the “reality” is real or the views “true” is irrelevant to examining policy interactions.

52 Social scientists applying Kuhn’s model generally hold that actors operating in one paradigm cannot communicate with those operating from another. That serves as an important assumption because it rules out learning and adaptation. Consequently, a perspective must be chosen in whole, and all thinking must go on within it. Change is always by quantum leap, through a revolution.
institutions and both to interests, albeit the relationship is contingent. In that sense, the concept of ideology is classically Marxist.

Following Sabatier and Hall, it is postulated that each actor in a policy community will have a distinct set of ideas, but understood as a frame of reference, not as discrete beliefs and preferences. This postulate is reasonable because no actor can be cognitively open to all aspects of reality. Each is closed to those aspects to which they ascribe no meaning (or to which they ascribe a different meaning). Processes of social closure - including only those who share a perspective - contribute to cognitive closure in a community.

The tighter the policy network, the more closed it is, the more it will be typified by a dominant frame of reference. Likewise, the more dissimilar the frames of reference, the less understanding there is between actors and the greater the social closure (Schaap and van Twist, 1997; Termeer and Koppenjan, 1997). Further, the greater the divergence in frames of reference, the lower the prospects for policy conflict resolution.

In a political system, the struggle among competing frames is a struggle for power, the power to define a situation authoritatively for all participants in the system and thus pre-structure the way interests can be articulated, claims be made and policy decisions be taken. (Jachtenfuchs, 1996; p. 29)

The theoretical position informing this study is distinct from the two naïve propositions that are often set out in opposition to one another. One proposition is that policy change is a function of learning. The other proposition is that policy change is a product of conflict between organized interests. The former is grounded in ideas and knowledge; the latter regards ideas as rhetorical camouflage. The foregoing analysis shows that treating ideas and power as dichotomies is misleading. Power, ideas and interests are interrelated and context bound. Any adequate account of policy change must be based on that understanding.

Light (1997) developed a useful typology of frames of reference for different parties engaged in health reform in the United States. Importantly, Light’s position links the cognitively enabling and limiting dimensions of frames of reference to social action. His typology classifies “patterned and meaningful action orientations” (Kalberg, 1994; p. 29).

Social and cognitive closure may also be deliberate and conscious - the “second face of power” explored by Bachach and Baratz (1962). That is, perspectives or actors holding certain perspectives may be ruled out - forced off agendas or not permitted to participate. Contrariwise, actors with different views may be consciously and strategically included. Motives may include co-optation or strategic alliance. For example, fascists and civil libertarians may join forces to fight censorship of internet sites. The theoretical focus in this study, however, is longer-term power relations, not transient “power plays”.

See, for example, John Lavis (1998) “Ideas, Policy Learning and Policy Change: the Determinants of Health Synthesis in Canada and the United Kingdom”, CHEPA, Paper 98-6, Hamilton:McMaster University. Lavis assumed theories must be either idea or power based.
31) Each of these “prototypes” represents a cluster of goals and ideas associated with a perspective on the health sector.

2.9.1 The British Columbia Health Policy Community

Before Light’s typology of frames of reference can be applied to the B.C. case study, the relevant policy actors must be identified. The concept of “policy community” must be operationalized to the specific features of the B.C. health care sector.

Policy communities and networks can be best conceptualized as a continuum (Rhodes and Marsh, 1992; Smith, 1993; Hall, 1993).

| Policy Network Continuum

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Policy Community</th>
<th>Issue Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership</td>
<td>Limited number of members; actors have a material interest in the sector</td>
<td>Large number of members; wide range of interests</td>
</tr>
<tr>
<td>Integration</td>
<td>Bargaining and negotiation; frequent interaction</td>
<td>Consultation; unstable interaction</td>
</tr>
<tr>
<td>Institutionalization</td>
<td>Consensus on policy principles and procedures; shared ideology</td>
<td>Conflict over ideology, principles, procedures and approaches</td>
</tr>
</tbody>
</table>

The policy community literature drives the conclusion that provincial governmental actors, professions, and unions form the B.C. health policy community. They are joined by the health advocacy organizations, single-issue pressure groups, consumer organizations, the academic community and a large and fluctuating number of other groups to form the health policy issue network.

The analysis must be sensitive to different dimensions. The first involves the interaction between organizational actors. On this dimension, the relevant variables are the interests of the actors, the degree of their interdependence, the members included in the community, and ideology. The second dimension involves the organizational actors themselves. The relevant variables are interests, ideology, cohesion and resources. It is crucial not to conflate the two dimensions.

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56 This is a modified version of a continuum developed by Daugbjerg (1998). It draws from Hall (1993), Smith (1993) and Howlett and Ramesh (1995).
Within the policy community, conflict is typically over the distribution of costs and benefits. The existing organizational configuration and frame of reference are assumed (Howlett and Rayner, 1995, p. 393). Debate takes place over the choice of policy instrument – incentives and sanctions, regulation, self-regulation, etc. – and the settings for those instruments (Hall, 1993). For example, shifting health care dollars from hospitals to home care (assuming similar services in each of the venues) involves only a change in the settings of existing policy instruments – the global budgets allocated to each sub-sector. While contentious, the debate is qualitatively different from a debate provoked by a policy proposal that calls into question the value and purposes of health care spending. That second type of conflict “relates to the ideational basis” of policy (Howlett and Rayner, 1995; p. 393). That second more fundamental type of conflict is best understood as a policy controversy grounded in the different frames through which the institutional actors understand the context, their interests, and their options.

Howlett and Ramesh argued, and the primary case study’s data confirm, that policy-related activity is typically concentrated amongst organized groupings with a material interest in that policy sector (Howlett and Ramesh, 1995). Actors with a material interest are those who are in a position to incur substantial material gains or losses through policy change. The principal material interests in the B.C. health care sector are:

1. Professional health care providers’ interests. These lie in maintaining dominance over the health care system and maintaining providers’ incomes.

2. Unionized health care providers’ interests. The unions’ principal interests lie in maintaining jobs for their members and securing wage and benefits gains on their behalf.

3. Commercial health care providers’ interests. The largest and most powerful actors are pharmaceutical companies and medical-surgical equipment and supply industries. They have an interest in expanding markets for, and controlling prices of, their services.

This suggests, although does not entail, that groups with distinct ideas about policy may not organize and attempt to influence policy outcomes unless their material interests are affected. A possible exception is the academic community, at least insofar as their activity is other-regarding. But even here, the availability of grants, and access to information and other resources through connecting with policy makers (i.e. the material interests of academics engaged in policy) are part of the context of interaction.

The proposition that policy-related activity is normally concentrated among actors with a material interest in the policy outcome in no way denies the importance of ideational or principled motives or the importance of different policy frames to policy actors. The relationship between frames and interests is contingent; actors tend to adopt views that align with their interests and interpret their interests through their views. This does not come to the same thing as saying actors engage in the policy process because they seek material advantage.

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Only the first two, professionals and unions, are directly relevant to this study. Because of the federal structure of the Canadian state, and because of the issues facing the multinational drug and medical equipment industries, the commercial sector focuses its efforts largely on the federal level of government and issues relating to federal regulation.58

The other key actor is the state itself. The state in a liberal democratic capitalist society must maintain the conditions for a prospering economy and act to preserve the legitimacy of principal state and societal forms. It is through the state that professions and unions enjoy their legitimacy, protections and privileges and it is only through them that the state can influence health care delivery (Hall, 1993; Smith, 1993).

2.9.2 Frames of Reference and the B.C. Health Care Policy Reform

Adapting Light’s typology to the B.C. health reform case yields four conceptual prototypes: (1) the frame of the government, qua state; (2) the frame of the health care professionals; (3) the frame of the health provider unions; and (4) the frame Light referred to as “community health care” (Light, 1997). The first, the government, qua state frame, is comprised of the beliefs, values and goals abstracted from the post-world war two policies of advanced capitalist states (virtually all OECD countries with the notable exception of the United States). It is referred to in this study as the “conventional welfare state” frame. Its core is the understanding that the state should defray the cost of all medically necessary services. The second is the health professional or organized medicine’s frame (“the medical model”). Its core is the relationship between the skilled practitioner and the patient. The third is the union or organized providers’ frame abstracted from the positions of the major health care unions. Its core is the equitable provision of state managed services. The fourth is the “community health” frame. Unlike the other frames, it was consciously developed in opposition to the health professional frame (“the medical model”), primarily by academics, but also by elements within the nursing profession. Its core is the assertion that the development of conditions contributing to community wellness is far more important to human health than the provision of medical services.

The state, professional and provider frames are drawn directly from the positions taken by existing actors within the established health policy community – the ministry, organized medicine and unions. The community health frame is associated primarily with health services’ academics, particularly academic nursing. Consequently, the community health frame, expressed as an ideal type, takes on the appearance of a principled, altruistic position. That appearance is enhanced by the absence of an obvious

58 The commercial sub-sector is active through media manipulation and direct lobbying of health care professionals. It also intercedes when specific issues (such as reference based pricing for publicly funded drugs) arise on the policy agenda. However, that activity is of an interest group nature; it is not characterized by a persisting relationship with the state.
institutional actor whose interests would be advanced by the frame. The appearance, however, is misleading.

Academic nursing for some time had been casting about for a theoretical foundation, rationale, and set of distinct goals for the profession to distinguish it from practice under the guidance of doctors. Until recently, the nursing profession attempted to address the hegemony of organized medicine head-on through cultivating the model of the nurse practitioner. As Robert Evans pointed out, nursing’s professional leaders had to find somewhere else to go ideologically following the failure to sell the idea of nurse practitioners to policy makers in the 1970’s. That place was “wellness” and the “community health frame”. Rather than arguing for a larger serving for nurses at the traditional health care feast (as advocacy for nurse practitioners did), promoting the community health frame questioned the legitimacy of the banquet. From the point of view of nursing’s interests, delegitimating medicine (through undermining the policy frame that gives medicine its status and claims on public resources) could serve as an alternative way of creating fresh opportunities for nursing. The Registered Nurses’ Association of B.C., for example, attempted to carve out a larger advocacy role for nurses. It argued that the responsibility of nurses extends to providing supports to family members and other patient collaterals, mobilizing social and financial resources on behalf of patients and addressing housing, social welfare, parenting, and lifestyle issues, at both the individual and collective levels. According to the RNABC, rather than patients, nurses deal with “clients”, either directly or through other agencies on the “client’s” behalf. The RNABC also claimed that the community as a whole is a client, and that nurses are responsible for advocating for the community’s health. Those community health and advocacy components are core to the RNABC’s claim that all future registered nurses must have university degrees. They also relate to the RNABC’s use of its authority to license provincial schools of nursing to force those schools to emphasize wellness and community practice, rather than patient care. Similarly, the Canadian Nurses’ Association began in the 1990’s redeveloping the national nurse registration exams (CNATs) to require competency in health promotion, client advocacy, and community wellness.

There is no implication that the community health frame (or any of the other frames) is a belief-set of convenience, adopted strategically for a material purpose. Frames cannot be construed as sets of ideas adopted because they suit one’s interests, because it is through frames that actors understand what their interests are. Instead, nursing’s relationship to the community health frame illustrates how ideas appeal to actors in a certain institutional context and then lead those actors to construe their goals and interests in particular ways.

Interestingly, the community health frame appealed to academic nursing and the professional regulatory body, but not to nurses in practice or the union representing them. Nurses-in-practice were more concerned with keeping their place at the health care banquet table – retaining work in hospitals and other conventional health care settings. Consequently, the community health frame was left largely ungrounded in an institutional context.

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59 private communication.

context, without a structural interest in support of it. It appealed to only a loose coalition of reformers, academics and the Registered Nurses’ Association of B.C.. The absence of structural support proved to be a fatal weakness.

### Typology of Interpretive Action Frames

<table>
<thead>
<tr>
<th>Values/Goals</th>
<th>Welfare State</th>
<th>Health Care Professionals</th>
<th>Health Care Unions</th>
<th>Community Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Values/Goals</td>
<td>To provide comprehensive health care services in an accessible and equitable way.</td>
<td>To provide the best possible quality care to every sick, injured or disabled person.</td>
<td>To expand the range and scope of publicly funded health care services.</td>
<td>To develop programmes that minimize disease, disability and premature death.</td>
</tr>
<tr>
<td></td>
<td>Minimize illness.</td>
<td>Maximize therapeutic and diagnostic capability.</td>
<td>Maximize accessibility to health care services provided by union members.</td>
<td>To promote ties of mutual support.</td>
</tr>
<tr>
<td></td>
<td>Minimize cost</td>
<td>Maximize professional autonomy.</td>
<td>Maximize the scope of practice of members.</td>
<td>Minimize impacts of illness and disability on families and the community.</td>
</tr>
<tr>
<td></td>
<td>Maximize accessibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Image of Individual</td>
<td>Dependant: the responsibility of publicly funded programmes.</td>
<td>A private person exercising their own choices.</td>
<td>A potential patient.</td>
<td>A member of the community.</td>
</tr>
<tr>
<td>Key Institutions</td>
<td>Ministry of Health, health authorities; professional associations; unions; Medical Services Commission.</td>
<td>Professional association, individual practitioners, hospitals, state (protections, privileges and funding)</td>
<td>Union, unionized sub-sectors of the health care sector, state</td>
<td>Community institutions (i.e. boards and committees), state</td>
</tr>
<tr>
<td>Organization/Division of Labour</td>
<td>Integrated, bureaucratic, delegation and substitution</td>
<td>Hierarchical, levels of expertise, limited delegation and substitution</td>
<td>Bureaucratic, limited delegation and substitution</td>
<td>Egalitarian and participatory</td>
</tr>
<tr>
<td>Funding</td>
<td>Public only (state)</td>
<td>Public and private.</td>
<td>Public only (state).</td>
<td>Public (state and local community)</td>
</tr>
</tbody>
</table>

The four prototypes are intended to link agency and structure by focusing on the elements that would motivate actors to pursue certain policy ends. Thus they are both interpretative (i.e. a way of regarding an aspect of the world) and action orientations (i.e. imply motives and goals). Those orientations “are neither average types nor a typical clustering of characteristics, as in the typical teenager or the typical computer company, but the conscious highlighting of essential features and motives from the real world” (Light, 1997; p. 110). Nor are these prototypes rhetorical representations of reality. Rather, they have, as noted above, two aspects: “They serve as filters for actors using them to make sense of the world (interpretive frames) and as frameworks of rationality guiding their action, even to the extent that they are actively promoted (action frames)” (Jachtenfuchs, 1996; p. 43).
The prototypes, purposefully sketchy, represent common extracted elements from the positions held by the primary policy sponsors – state, professionals, providers and advocates for policy reform (the coalition of academics and community health activists). The actual empirical and normative content of institutional actors’ frames will be inferred through the process of documentary review and interviews and compared with the prototypes. Their prior identification is, however, necessary from a methodological point of view. As has been argued, there is no “frame free” perspective on reality, and the frames need to be explicitly constructed in advance to guide the study’s data collection and analysis.

The study will then sketch the background conditions to the New Directions health reform policy. The frame implicit in New Directions and the changes that occurred to it during implementation will make up the bulk of the following chapter. The fifth chapter will explore the frames of the medical profession and the health care unions.

Referring back to the table of prototypes of health care system, it is important to note that the orientations across the first three sponsors are amenable to a qualitatively different response than any of the first three sponsors’ orientations with the fourth. In other words, there is more common ideological ground amongst government qua state, health care professionals and unions than exists between any one of those sponsors and the conceptual prototype of community health.

Government qua state, professions and unions all value a comprehensive system of health care services accessible to each person on an individual basis. Two key differences amongst them turn on the axes of expertise versus bureaucratic predictability and cost-containment versus open-ended funding. Both can be negotiated to compromises and both are essentially distributive questions. However, the state, professions and unions fundamentally disagree over organization and division of labour – in short, power dimensions. Those disagreements involve principles and consequently, as the case study demonstrates, are intractable.

The community health perspective shares almost nothing with the other frames. Its foundation is different. The community health perspective is grounded in health outcomes for the community, whereas the other three perspectives are grounded in the provision of services to individuals. Thus, while each perspective importantly differs from each of the others (and therefore will lead its advocates into conflicts) the community health perspective marks a major difference in the “ideational basis of policy”.

A disagreement over how policy should be understood, its fundamental aims, and the principles that ought to inform it is inherently destabilizing. For example, it may politicize the sector, driving actors to seek allies and to mobilize the public. The policy community may fragment, it may expand or the policy sponsors may attempt to forge a new one out of the policy network members. Those are the conditions for substantive policy change, what Hall refers to as “third order reform”. Policy objectives, instruments, instrument settings and basic policy principles may all change (Hall, 1993).
Such policy confrontation ("policy controversy") is "high cost" since the new instruments will inevitably concentrate costs on the groups affected. The policy objectives run counter to the ideas and interests enshrined in the existing policy and operationalized through the existing organizational forms (Daugbjerg, 1998, p.71).

It was the promise of substantive, high cost policy change that makes the B.C. health care reform initiative of theoretical interest. The government consciously adopted a "community health" orientation, thus deliberately departed from policy making within the established policy community. While engaged in "third order reform" it hedged its bets through accords with both the professions and the unions. The effects of this approach are examined in chapters 3 and 6.

Summing up, the primary case study focuses on explicating the frames of reference of the key institutional actors and how those came to find expression in British Columbia’s health policy as a result of the interaction of the institutional actors. By analyzing the operation of ideologies in the sector, it is possible to establish links between the way issues are defined, how resources are allocated, the expression of underlying interests, and the distribution of power.

The approach involves analyzing the positions of the parties -- state and societal actors -- in terms of the changing context and the shifting ideological content. That ideological content is operationalized as inferences from documentary sources regarding:

- the actor’s values. What should the goals be for the health system?
- the actor’s views of who should be involved in health policy formation and implementation. Who are the legitimate parties to the dialogue about health services?
- the actor’s views regarding the individual. Does the actor conceive of the individual as a recipient of public services? a client or consumer? a patient? a member of a community?
- the actor’s views regarding the key institutions. Are the key institutions government, the bureaucracy and professional associations? professional associations and practice sites? unions, unionized facilities and state actors? community institutions and the state?
- the actor’s beliefs and values regarding institutions and the division of labour. Does the actor favour integrated systems with clear delegation? hierarchical, expertise-driven systems? egalitarian and participatory ones?
- the actor’s views on financing. Should health care financing be public only? a mix of public and private financing?
- the actor’s views on the roles of citizens, patients, consumers and health care professionals in controlling service delivery. What are the legitimate roles of the public, the professionals and the health care providers?
The documentary sources are: the *Royal Commission on Health Care and Costs* (the Seaton Commission), Ministry of Health publications on health reform from 1991 to 1997, Ministerial speeches from 1991 to 1997, documents produced by the British Columbia Medical Association, the Health Employees Union and the B.C. Nurses’ Union (1991 to 1997). The choice of organizations for document sampling reflects the sampling decisions made for key informant interviews.

Sources for data on the degree and nature of interaction amongst the institutional actors are documentary evidence such as records of meetings, as well as informed source interviews. Those key informant interviews are also used to corroborate documentary findings regarding the actor’s frame of reference, what role the actor believed itself to be playing in the reform process, degree of ideological congruence with other actor(s), non-governmental actors’ access to governmental actors.

The sampling frame is determined by the material interests of the actors and the identity of the representative(s) drawn from the institutional members of the policy community for formal consultations with the state. Those formal representatives joined others in a state-forged policy network that served as an advisory committee to the health care reforms.\(^6^1\)

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\(^6^1\) *New Directions* was inaugurated through the establishment of a Deputy Minister’s Advisory Committee, which over its life was comprised of between 35 and 45 members of the B.C. health policy network. A full list (final membership) is included as Appendix C.

Drawing the key informants from the membership of the Deputy Minister’s Advisory Committee is appropriate because those people:

- were selected by, and therefore presumably seen as legitimate spokespersons for, their respective organization
- were charged with formally representing their organization
- were informed regarding both their organization’s position and that of other organizations, including government
- were active throughout the critical period of policy implementation (1993 to 1996).
2.9.3 Methods

The first step of the study was the documentary analysis. That analysis classified the data according to:

- the institutional actor’s values regarding equity, the provision of high quality care, patient choice, professional autonomy, access, the incidence of disease and disability, mutual support, and community participation;

- the institutional actor’s view of the individual as the recipient of services, a consumer, a client, a patient or a member of a community;

- the institutional actor’s beliefs regarding key institutions such as government, bureaucracy, professional associations, practice sites such as clinics and hospitals, unions, health facilities and community institutions;

- the institutional actor’s beliefs and values regarding institutions and the division of labour (their positions on integration, delegation, devolution, expertise versus consistency, centralist and bureaucratic approaches versus egalitarian and participatory ones);

- the institutional actor’s views on public versus private financing of health services.

Specific positions on the election of health governing boards, who should be entitled to sit on governance bodies, the proper extent of authority for those boards, and the appropriate scope of their decision making power were extracted from the documents and compared across the actors and over time.

Documentary analysis was conducted by identifying the positions taken on the five clusters of variables and by following key themes related to health and health services, devolution, scope of action for the new health authorities, elections, taxation, and accountability. Analysis was purposefully contextualized in time, in terms of concurrent decisions and behaviour of other actors and the response to the documents by other parties. Content analysis was not used because it is insufficiently sensitive to contexts without the importation of unrealistic limiting conditions. A secondary consideration was the assumption that the content of the government’s health policy would inevitably change as policy moved from expressions of principle through the phases of implementation. The object was not to show that policy changed, because that was wholly predictable. Rather the object was to show how and why it changed, along with the significance of those changes.

The second step of the study was a series of in-depth interviews with senior ministry of health officials, health union leaders and the leaders of the British Columbia Medical Association. Those interviews explored the five clusters of variables examined in the documentary analysis stage. The transcripts were analyzed in the same fashion.
Additionally, the interviews explored the institutional actors' views regarding who was influential in the policy implementation process and why they were influential. Respondents answered questions regarding whom they interacted with for what purposes and to what effect. Sample interview questions are included in Appendix B.

The third stage of the study was a review of the minutes and reports of the Central Okanagan Steering Committee, the Central Okanagan Community Health Council, the South Okanagan Similkameen Regional Health Board and the Okanagan Similkameen Health Board. Documents spanned the period 1993 to 1997. The purpose of the review was twofold. The first was to determine the reactions within one of the regions in the province to the shifts in provincial policy and the activities of the other institutional actors; the second was to aid in the construction of the regional health board questionnaire (Appendix C). That questionnaire was administered in the spring, 1999.

The fourth stage of the study was a series of in-depth interviews with the Okanagan Similkameen health board members, medical staff, health care managers and the chief executive officer. The interviews were designed to discover what changes had occurred with respect to organization, management and health service delivery as a consequence of the reform. The interviews with board members were also designed to determine their views on accountability and control. Sample interview questions are included in Appendix B.

The final stage was the acquisition and analysis of regional health board budgetary and expenditure information. This stage also involved interviews with Okanagan Similkameen Health Region financial and programme officers.
CHAPTER III: Policy Framing

3.1 Agenda Setting: Interests, Institutions and Politics

Politics in British Columbia from the early 1950’s to the early 1990’s were dominated by a centre-right coalition made up of elements of the Social Credit, Conservative and Liberal parties. Originally organized around the person of W.A.C. Bennett, and named after the Social Credit charter group, the B.C. Social Credit party focused on economic development through lending public support to the private sector. By 1960, coalition building by the Social Credit party leadership was complete. Only one political party, the left-centre New Democratic Party (NDP), remained a functional alternative to the hegemony of the pro-business Social Credit coalition. The NDP, partly due to its left-of-centre ideology and partly due to the lack of other natural constituencies, grounded its support on organized labour. From the 1970’s onwards its base expanded to include environmentalists and public sector employees.

The formation of an omnibus pro-business coalition and a pro-labour opposition polarized politics in the province. Realities, however, did not align perfectly with the rhetoric. Although right-of-centre, the Social Credit coalition that governed the province for all but three years in the four decades between 1952 and 1991 intervened actively in the provincial economy. Social Credit governments created crown corporations such as B.C. Hydro and the B.C. Ferries Corporation. They invested heavily in public infrastructure such as highways and rail-lines. Those activities focused on building support to the extractive industries of mining and forestry, both of which lay in private hands. State-sponsored economic growth fostered expansion in the unionized labour force and in the size of the public service.

In 1972, a combination of scandals, the advancing age of the premier, poor economic performance and labour unrest finally defeated the Social Credit government. That defeat was “in part attributable to dissatisfaction among occupational groups the government had helped to create and nourish. The election was preceded by major battles with the hospital and government employees and with the doctors and schoolteachers” (Blake, 1996, p. 73).

The newly elected NDP government led by Dave Barrett was confronted by an array of possible changes. The twenty-year span of the Bennett government that preceded it created something of a time warp. B.C. reflected political and public administration principles that were more in keeping with the 1940’s than the 1970’s. “Having resisted many of the administrative and policy reforms that had become fashionable elsewhere, W.A.C. Bennett left the new government with plenty of opportunity to make changes” (Sigurdson, 1996, p. 322). In fact, the decrepitude of the provincial state apparatus, the highly personal “hands-on” style of governing under the Bennett government, and the
fact that the NDP had never experienced power conspired against the new government and contributed to its early demise (Tennant, 1977).

In spite of disorganization and a lack of infrastructure for implementing policy, the NDP managed to make a number of changes that had long-term implications for health care and health care policy. The government funded the construction of a large number of new hospitals and long-term care centres. It created a province-wide ambulance service and introduced Pharmacare - a prescription drug programme for all residents of the province. The government attempted a merger of health and social services departments within the bureaucracy and an integration of health and social services at the community level under regional boards. Most significantly, the NDP government moved to consolidate its support with organized labour and the swelling ranks of public employees. The government reversed Social Credit labour policies and introduced free collective bargaining. Labour organizing and bargaining rights were extended to the bureaucracy and to essential public services such as hospital services. Further, the government established the Labour Relations Board to ensure collective agreements were enforced.

The NDP government’s labour measures served to shift the locus of control away from public sector managers to the unions representing public sector employees. The power of unions such as the British Columbia Government Employees’ Union (BCGEU), the Health Employees’ Union (HEU) and the British Columbia Nurses’ Union (BCNNU) was enormously enhanced. The government also intended enhancing the power of the NDP over the public sector by forging a relationship between the party and the union leadership.

The union membership, however, was impatient for greater short-term gains. The rapidly deteriorating economic circumstances in the province, and the business backlash to the NDP’s policies, constrained the government’s ability to deliver. A series of strikes ensued. Those in the forestry and transportation sector were particularly damaging to both the economy and the government’s reputation. The government finally introduced back-to-work legislation, thereby incurring the wrath of their major supporter – organized labour.

The ambitious expansion of health and social services coupled with the unionization of those sectors caused costs to skyrocket. In one fiscal year (1974/1975), the new Human Resources Ministry managed to overspend its budget allocation by over 40% (Sigurdson, 1996, p 323). Uncontrolled government spending coincided with the 1974 collapse of commodity prices. The forestry and transportation strikes deepened the public perception that the economy was in serious trouble. Since the government-union accord collapsed along with the provincial economy, it was no surprise that the NDP went down to defeat in the 1975 provincial election.
The 1973-1975 NDP government provided important lessons for both the unions and the party. If the NDP was to achieve anything other than ephemeral electoral success, it needed to improve its reputation as a manager of the economy. The disasters that befell it during the brief time in office left the party with an obligation “to demonstrate to the owners and managers of private capital that they will not transform too radically the economic status quo” (Sigurdson, 1996, p. 319).

It was also evident to both the union and the NDP leadership that their relationship must become more effectively institutionalized; communications and coordination needed substantial improvement. The union leaders also learned they had to be more active and effective in disciplining their members if they were to achieve longer-term policy outcomes favourable to labour’s interests.

Their brief period governing, and their major defeat in the polls, made it clear to the NDP that the support of the B.C. Federation of Labour and public sector employees was not enough. The party also had to broaden its support base by appealing to environmentalists, women voters, and university faculty, social workers, nurses and teachers - the “new professional class” that had grown as a result of burgeoning public expenditure.

The return to power of the Social Credit party in 1975 did not bring, at least initially, a major change in policy direction. Labour legislation was amended to make it more favourable to private sector employers, but public sector union rights survived. The NDP’s attempts to merge health and social services, however, were abandoned and the experiment with regional health and social service boards ended. The health sector reverted to the (albeit more heavily unionized) status quo.

The Social Credit government of 1983-1986 marked a major change in policy direction. Premier Bill Bennett (son of W.A.C. Bennett) responded to the intractable public debt problem with a full-blown endorsement of new-right politics. British Columbia became an early adopter of a range of initiatives that were later associated with the Reagan presidency and the Thatcher government. Those initiatives were grounded in a belief that the downward trend in the economy could only be reversed by a two-pronged strategy. The first prong was to provide freer reign for market forces; the second prong was to make massive cuts in public expenditure.

Comprehensive reductions in public spending were followed by waves of privatization and devolution ranging from highway maintenance to B.C. Hydro. The influence of the free-market ideas of the Fraser Institute, a business-sponsored right-wing policy group based in Vancouver, began to be felt throughout the provincial state apparatus. Public services such as childcare were transferred to non-profit agencies. Regulatory and social rights agencies such as the Human Rights Commission and Employment Standards Board were abolished. The Ministry of Health sustained a 27% reduction in staff (Prince, 1996, p. 256). Physician fees were frozen. The government attempted to regulate the number of physicians in practice (and their location of practice) through limiting the right to bill the public medical insurance plan. Over 1200 hospital beds were closed. Services to high-need populations were disproportionately cut; for example, community health
centres and clinics were either shut or substantially reduced in size. Services to women were also targeted; Planned Parenthood and the Vancouver Women’s Health Collective saw their funding completely eliminated (Prince, 1996, p. 256). The diversity, range and capacity of services across the health care sector shrank dramatically.

Bill Bennett resigned in 1986 and was replaced as premier by Bill Vander Zalm. Vander Zalm’s Social Credit government brought another element to the new-right ideology of the preceding Bennett one – Christian fundamentalism. Vander Zalm, displaying a curiously idiosyncratic and personal style of leadership reminiscent of W.A.C. Bennett, made a major policy issue out of his personal abhorrence of abortion. In 1987, Vander Zalm’s government began channeling public funds to agencies opposed to abortion. In 1988, his government withdrew all public funding for therapeutic abortions. That action was successfully challenged in court. The government’s response to the legal challenge was a $2.2 million dollar anti-abortion advertising campaign and a $20.0 million programme aimed at pregnant women and single mothers. The government also supported the continuing right of hospital societies to elect the boards of trustees for public hospitals in spite of complaints that church groups were “packing” society meetings in order to elect anti-abortionists to hospital boards.

Focusing on the abortion issue, sustaining Bennett’s adversarial labour relations posture, and unilaterally changing the benefits provided under medical care insurance by de-insuring abortion, thoroughly politicized the health care sector. Vander Zalm’s avowedly Christian-populist style, and his capacity to ignore advice from party members and the business community, alienated the pro-business coalition as well as the general electorate. When Vander Zalm became engulfed in personal financial scandals, both the Social Credit party and the pro-business coalition upon which it was built quietly shifted over to the shell of the old Liberal party. The Social Credit party and the Social Credit government simultaneously self-destructed.

Prior to the collapse of his government, Vander Zalm appointed the Royal Commission on Health Care and Costs. The Commission did not, however, report out until after the Social Credit government went down to defeat. Health care reform thus forced itself early onto the agenda of the Harcourt NDP government, elected in 1991.

The NDP government did not want to respond immediately to the Commission Report. Caution was the by-word, given the experience the NDP had with reformist zeal under Barrett. Instead of acting on the report, the government established a parallel process involving a 24 member advisory committee, on the one side, and an implementation team within the Ministry of Health, on the other. The choice of a parallel process was an early signal that the new government did not trust senior ministry officials. It regarded the bureaucracy in general, and the ministry of health in particular, as contributing to the

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62 While a number of services have been de-insured by Canadian provinces (eg. neo-natal circumcision and some fertility treatments), changes in “medically necessary” and hence insured services have always been made in consultation with, and with the agreement of, the provincial medical association. Vander Zalm’s government violated that important convention.
perceived problems with the health care sector. The suspicions were partly based on policy and ideological considerations, and partly based on the assumption that the loyalty of officials who had worked their entire careers under a Social Credit regime was questionable.

The choice of participants in the advisory process also signaled the high degree of suspicion that the government had of the health care professions, especially doctors. The government tried to manage both its own officials and the medical profession through the reform process—an approach that had profound implications for the reform effort.

The government’s published response to the Royal Commission on Health Care and Costs finally came in 1993. It took the form of *New Directions in Health Care for Healthy British Columbians*.

As *New Directions* was taking shape, the government began talks with the health care unions. The government assumed from the outset that health reform would involve some kind of regionalization and recognized early on that the patchwork of collective agreements in the health sector would be a major obstacle to integration of services at the regional level. The government set two key goals. The first was to rationalize collective agreements so that any planned mergers of hospital, extended care and community health services could proceed without labour disruptions. The second was to reduce acute care staffing levels by 10% (4,800 positions) and transfer those resources to less expensive alternatives such as home care. The strategies included a mix of early retirement, attrition, and statutory preference for hiring within and across health care sub-sectors.

The Healthcare Labour Adjustment Agency was formed to place redundant unionized employees in related jobs anywhere in the province.

Once province wide bargaining began, the scope of government-union involvement could not be limited to the government’s agenda of establishing the minimum prior conditions for regionalization. The government wanted to solve the problem of employer of record; the unions pressed for job security provisions and for superior benefits across-the-board. They also pressed for the full unionization of sub-sectors that were non-unionized or partially unionized. The process had the unintended consequence of sidelining the parties who remained (until regional authorities were constituted) the employers—i.e. the hospital boards and the employers’ association. The unions, as a result of the labour accord process, could bargain directly with the government on a provincial basis. Local bargaining tables were by-passed. The power gained by the provincial unions was amply demonstrated when, in 1996, the government endorsed a province-wide agreement that was overwhelmingly rejected by the hospitals that actually employed and paid the staff.

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63 Both the Advisory Committee on Labour Adjustment to the Minister of Health and the Labour Adjustment Board (with representation from the B.C. Nurses’ Union, Hospital Employees’ Union, and the Health Sciences Association) pre-dated New Directions. The Health Accord, signed in August 1993, gave 55,000 workers in three health care unions job security, a reduced work week, and a guaranteed voice in restructuring B.C.’s health care system.
In short, the NDP government, heavily dependent upon union support, institutionalized an arrangement whereby the major unions dealt directly with that government through the machinery of the labour adjustment process. “The labour accord and working agreement (with the BCMA) were formulated by the provincial government in close collaboration with union . . . elites” (Prince, 1996, p. 262). The accord represented a move to corporatism, an organized interaction between the state and labour that determined the allocation of public resources.

As will also be shown, the emergence of corporate forms forced a change in government policy. The regional health authorities could no longer be considered the employers of record with rights to bargain collective agreements with their unions. Province-wide bargaining displaced the regional authorities before they were even formed. Consequently, the regional authorities’ scope of authority, and their power to effect change in their area of devolved responsibility, were substantially reduced by the time powers were actually devolved to them.

In a parallel process, the Harcourt government negotiated an accord with the British Columbia Medical Association. The Medical and Health Services Act (1992) established co-management of health care resources by government, the BCMA and public representatives. The Medical Services Commission created by the Act had a nine-member governance structure – three from the bureaucracy, three from the BCMA, and three from the public.

Again, the form was corporatist – a closed policy community that institutionalized interaction between the state and medical practitioners and determined the allocation of public resources. Institutionalized co-management had the profound effect of removing physicians’ services from the health reform agenda. It excluded from the direct control of the regional health authorities the terms and conditions under which medical services would be performed, and therefore effectively undermined any real scope regional authorities might have had around issues of substitution and coordination of care.

As in the field of labour relations, the government tried to minimize resistance to regionalization by making a deal with a constituency affected by it. The form the deal with the BCMA took was heavily influenced by past experience and ideology, as was the case with the health care union labour accord. The historical and ideological factors specific to government relations with the BCMA are explored in the next section.

In conclusion, prior to regionalization getting off the ground, both labour relations and medical services were exempted from the reform process through special prior arrangements. The main factor driving the corporatist approach to the unions was the learning that took place under the Barrett government. Both the union and government elites recognized the need to institutionalize their relationship. The main factors driving the corporatist approach to the BCMA were likewise grounded in the history of conflict between government and the profession, as well as ideological factors such as the professional prerogatives enshrined in medicare regarding the relative values for fees and clinical autonomy.
3.2 Frames, Institutions and Path Dependency: Medical Services Insurance

The inspiration for Canadian medical care insurance policy was the 1964 *Report of the Royal Commission on Health Services* (Hall Commission, 1964). The report was premised on a set of interrelated beliefs and values regarding the role of physicians and the impact of their services on the health of Canadians. Providing a greater volume of medical services was believed to be a necessary condition for a healthier population. Barriers to public access to doctors’ services – whether financial in the form of fees people cannot afford to pay or limitations in the supply of medical practitioners – were construed as barriers to good health.

It is not surprising that the Royal Commission on Health Services, struck by the federal government in the first instance at the insistence of the Canadian Medical Association, held a perspective so closely aligned with the ideology and material interests of the medical profession. Nor is it surprising that the Commission agreed with the Canadian Medical Association and its provincial affiliates that the principal issues facing health care in Canada were under funding and under servicing. The surprise came in the form of the recommendation that provincial public funding for medical services should be channeled through a single public agency responsible for the medical insurance coverage of the entire population.

The recommendations that a new insurance plan be universal, publicly administered and funded solely by public revenues flatly contradicted the Medical Association’s position that state involvement should be limited to subsidizing private insurance and medical schools. The BCMA, in particular, worried that a plan depending on public financing would be subject to government influence (Taylor, 1978, p. 349).

Because the B.C. provincial government required the cooperation of the medical profession to implement the medical insurance plan, and because the precedent had been set in Saskatchewan and other early Canadian adopters of medicare, the B.C. government granted considerable autonomy to the BCMA regarding the organization and policies of the new Medical Care Insurance Commission. The provincial government also conceded the right to the BCMA to set the relative value of fees charged by doctors to the public plan. In addition, the government acceded to professional pressure for patients to retain the right to consult whichever physician they chose, whenever they chose, subject only to referral by general practitioners to specialists.

All governments that implement medical insurance plans need to come to terms with the medical profession. Dohler (1989) found evidence in five OECD countries that agreements take the form of trade-offs of economic autonomy for clinical independence.

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64 “The small business mode of FFS (fee for service) practice was enshrined in the 1964 Royal Commission Report that set the stage for Canada’s contemporary medicare programs.” (Naylor, 1999; p. 7).
However, the original bargain in B.C. did not take that form. The profession retained, in fact strengthened, both its economic and clinical independence.

Publicly funded medical insurance, at least in the B.C. case, merely supplanted a set of near-universal private insurance arrangements with fully universal public ones. The B.C. Medical Care Insurance Plan, implemented in 1968, “essentially froze in place the system of health care delivery that existed in the 1960’s and underwrote its costs” (Tuohy, 1996).

In spite of a “win-win” situation for the BCMA, their position remained cautious. The B.C. medical insurance system was now a single-payer system dependent entirely on public funds. Medicare introduced the threat of government constraints on the amount and purposes of health care expenditures.

The introduction of universal medical insurance into B.C. was neither intended to, nor did it, change the substance of provincial health care policy. In both practice and perception, the public insurance plan merely replaced the social security provisions which previously provided financial protection to the indigent, and generalized to the entire population the not-for-profit insurance arrangements which previously provided coverage for the bulk of the working population. Thus, while public medical care insurance was an important new programme, it involved only changes in policy instruments and their settings, not a new policy orientation with regard to medical care. The most important change was the shift to direct public administration of health insurance, a shift that strengthened the clientelist relationship between the state and the medical profession.

Universal, public medical care insurance did, however, have important effects on future prospects for policy. In particular, it institutionalized the beliefs and values of the Hall Commission regarding the link of medical services to health and the connections between both to citizen rights. It delegated organizational power and prerogatives to the provincial medical association, legitimized the profession’s practice of setting the relative value of fees, and created incentives for the expansion of medical services. Universal public insurance entrenched the right of all provincial residents to free access to whatever medical services they and doctors thought necessary. Importantly, it also created the conditions for a conflict between the government and organized medicine over the appropriate level of public funding for medical services.

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65 Important markers of continuity were the continued use of the expression “insurance” to describe the universal public plan and the incorporation of a requirement, largely mediated through employers, to pay premiums in support of it (rather than supporting the public insurance programme through taxes). Another way of expressing this is: the options of providing public subsidies to private non-profit insurers such as Blue Cross or providing cover under a publicly administered plan were regarded by provincial governments as alternative administrative arrangements, not hard policy options. Only the medical associations were exercised by the difference because the latter, public administration, meant the state would become the sole payer and therefore could conceivably exercise direct control over fees. See infra. p. 66. See also Taylor, 1978).
Public medical care insurance began with very few rules. Only “medically necessary” services would be paid for by the plan. Only one physician would be paid by the plan for providing the same service to the same patient in the course of the same illness. Specialists would be paid at the general practitioner rate unless the patient was referred by a general practitioner. A doctor could choose to bill the plan for all insured services provided to insured patients (eligible provincial residents) or, alternatively, bill for all services to their patients who could then seek reimbursement from the plan. A doctor was required to be entirely in or entirely out of the public plan – he/she could not split billings nor could he/she bill for some patients in one fashion and for others in a different one. Fees would be paid in accordance with the BCMA Relative Value Guide.

“Medically necessary” proved to be very elastic, stretching to cover everything from emotional distress to fertility treatments. Data processing capabilities in the 1970’s were not sophisticated enough to determine whether more than one service was performed by more than one doctor in the course of the same illness. Hence the “multiple servicing” rule became irrelevant. The “referral rule” operated to enhance general practitioner billings, rather than to constrain access to specialists. Only the “opting out” rule proved important, as it served to force physicians to stay within the public plan after government began to apply downward pressure on fees.

In sum, the introduction of medical care insurance, and its early operation, imposed no new limitations on medical practice or on fee payments. Substantive issues regarding the need for, the appropriateness and quality of, and the prices for, medical interventions were all left in the hands of the medical profession. In consequence, the programme’s most immediate effect was a sharp rise in physician income.

Those outcomes would be expected because physicians and government shared the belief that each case required expert diagnosis and treatment based on the unique presenting features within the private doctor-patient relationship. The fiction of a fiduciary relationship between doctor and patient was maintained, as was payment for each specific service rendered. How resources would be allocated to particular patients – referrals, admissions, level of nursing care, drugs, and procedures – remained individual doctors’ decisions. Mechanic (1994) referred to the approach as “implicit rationing”, and argued that it is grounded in a particular conception of clinical autonomy, one that implies medical dominance over other health care providers. It places doctors in the role of commanding how much of what kind of resources will be brought to bear on the treatment and care of a patient.

A critical institutional arrangement that was frozen into place by the provincial medical care plan was fee-for-service medicine. While previous public health and hospital practices of hiring some physicians on salary (notably pathologists and radiologists) continued, broadening of alternative payment mechanisms was foreclosed by the newly created incentive structure of a completely open-ended public payment plan. In

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66 See Medical Services Act, RSBC 1979 and associated regulations. The provisions were carried over without change into Medical Protection Act, RSBC 1996.
consequence, in 1998 over 90% of primary care and almost 100% of specialist care was provided on a fee-for-service basis (Naylor, 1999).

Alternative payment mechanisms have not evolved in B.C. or elsewhere in Canada due to the legacy of universal medical insurance. In spite of significant effort in the provinces of Ontario and Quebec, Local Community Service Centres (CLSCs) in Quebec include less than 10% of Quebec's doctors (Tuohy, 1999; p. 222). Health Service Organization (HSOs) and Community Health Centres (CHCs) in Ontario cover less than 5% of the provincial population (ibid.). Virtually all other medical services are fee-for-service.

A second critical institutional arrangement was the Medical Services Plan (MSP) itself. MSP was a new organization, nested within the existing Ministry of Health. In order to pay the flood of bills flowing in from doctors, it was equipped with an enormous budget. More significantly, MSP was linked to a powerful client group - practicing B.C. physicians.

The creation of MSP worsened the fragmentation of the Ministry of Health. Structurally, medical services were separated from community, public health, and hospital services. Conflicts over both resource allocations and policy directions within the ministry became endemic given the balkanization of its departments, the different clienteles, and the different mandates.

A third organizational outcome was the power the BCMA gained over its membership. Public medical care insurance made BCMA the official bargaining agent for doctors and their only means of establishing the economic value of their work.

Shortly after the introduction of medical care insurance, the deteriorating economic circumstances in the province, and the burgeoning cost of medical and hospital services (especially in the wake of the NDP interregnum), brought the government and the BCMA increasingly into conflict over resources. By the end of the 1970's, the BCMA was finding itself in the uncomfortable position of having to discipline its members to government imposed limits on public financing. Government/BCMA relations became increasingly confrontational (Tuohy, 1996).

Personalities inflamed the conflict. Premiers Bennett and Vander Zalm had adversarial approaches to labour relations and the “National Health Service Refugees” – doctors who left Britain for practice in British Columbia – took an equally intransigent approach to government.

The confrontational period culminating in the late 1980's was marked by strike threats, professional boycotts of public bodies, and recourse to litigation. In 1985, the government abandoned negotiations with the BCMA and (unsuccessfully) attempted to regulate billings to the medical insurance plan through the control of billing numbers. While the period was marked by more conflict than cooperation, neither medical care insurance as a programme nor the policy that informed it were reformed. Government had not yet changed its position on the role of medicine or the prerogatives of the
profession; it merely attempted a series of maneuvers to limit the cost of the programme. Those changes were in governing instruments and settings, not policy.67

By the close of the decade, both the provincial government and the BCMA were considerably bloodied. The public had tired of the recalcitrance and rhetoric on both sides. The BCMA was also acutely aware of the enormous blow to the reputation of the Canadian medical profession sustained in the failed 1986 Ontario doctors' strike.68 Both the government and the BCMA were motivated to de-politicize the sub-sector by returning to quiet, closed, bilateral negotiations.

The election of the Harcourt NDP government coincided with the new spirit of guarded cooperation. As was noted earlier, the new government wanted labour peace both with the unions and with the medical association to give it time to develop its health reform position. The new government brought no new policy ideas to the area of medical care insurance; instead it reinforced the old corporatist forms by institutionalizing them in the tripartite 1992 Medical Services Commission.

Importantly, the BCMA/government agreement did not mark a fresh policy direction. The medical-professional perspective that originally informed medical care insurance as public policy remained intact. In fact, the government emphasized its commitment to professional autonomy and BCMA president Dr. Derryck Smith described the new arrangements as “a boon to the medical profession”69.

Barer et.al. (1996) argued that the master agreement bringing temporary peace to government/BCMA relations involved a trade-off. It preserved the BCMA sphere of influence over clinical and professional issues at the price of caps on global medical expenditure. The government gave the BCMA joint management rights over medical

67 The 1970’s and 1980’s saw the emergence of the small area variations literature and the emergence of interest in evidence-based medicine. Concurrently, provincial governments learned that limits on prices for specifically described services did not control costs because both the description and the volume of services provided were in professional hands (Morris Barer, private communication). The underlying assumption, though, remained that medical services were an important route to public health. The perceived problem was that payment mechanisms and organizational structures contributed to inefficiencies of under and over-servicing. The problem was construed as a distributional one. That is very different from challenging the ideational basis of policy by suggesting medical services, whether appropriately structured or not, are only a minor determinant of health. See Naylor (1999) for an argument that health care policy change (from the 1960’s to the 1990’s) in Canada was incremental and comprised of only conventional fiscal and regulatory initiatives. Tuohy (1999) took a similar position.


69 Dr. Smith made the remark at the health policy conference “Nothing that is regular is stupid”, Centre for Health Services and Policy Research, 9th Annual Conference, University of British Columbia, 96/11/15. Others agreed that the arrangement entrenched historic physician privileges. The British Columbia Health Association, for example, noted: “The Conference of Deputy Ministers released the report ‘Paying the Piper and Calling the Tune: Principles and Prospects for Reforming Physician Payment Methods in Canada’ in 1994, which outlines payment options that focus on meeting health care objectives rather than determining physician incomes and controlling physician expenditures. . . . The current agreement between the BCMA and the government makes substantial progress toward implementing alternative payment strategies for physicians unlikely within the time frame of the agreement” (BCHA, 1995; p. 7).
insurance on the condition that the BCMA would discipline its members to caps on total payments to medical practitioners.  

Shortly after the reconciliation between the government and the BCMA, the Ministry of Health announced “responsibility for the Medical Services Plan remains within the mandate of the Ministry of Health. There will be no change in the current funding arrangements with doctors” (MOH, 1996). Services provided by physicians, amounting to a direct cost of 20% of health care spending and an indirect cost of over 50% of total health care expenditure, had been removed from the health reform agenda.

For over twenty years, academics criticized the organization of medical care and the implications of the “medical model”. Both they and alternative care providers ranging from nurses to holistic healers submitted briefs to the Royal Commission on Health Care and Costs attacking the hegemony of physicians and their interpretation of the requisites for human health. Community health centres employing doctors, and capitation and salary payment plans for physician services, have been recommended since the 1930’s. Yet no stable coalition formed in opposition to the conventional medical model. Thus in spite of persistent government/profession conflict and a good deal of sound and fury, medical insurance institutions survived from the birth of Canadian medicare through to the end of the century.

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70 The agreement included limits on physician supply, a provision that was uncontroversial since it benefited the practicing doctors who make up the BCMA membership. It also included provisions for the joint development of clinical guidelines. The key to BCMA acceptance of that provision lay in the voluntary nature of any such guidelines.

71 There were 296 submissions from various self-identified health care providers, only a small minority of whom were medical practitioners. There were 552 individual submissions, many of them from providers of health related services. There were 144 submissions from organizations representing health care “professions” (from herbalists to surgeons), only 29 of which came from organizations representing doctors or interns (Seaton, 1991d; pp. 65-78).

72 In 1933, the Saskatchewan Medical Association endorsed health insurance that would include payment forms other than fee for service (Taylor, 1978, p. 5). In 1943, the federal minister of health was quoted as saying “I am advised that there is now a swing on the part of the doctors towards capitation and I would suggest that, from a public standpoint, the capitation system is preferable because it will encourage the physician to counsel and urge preventive measures” (Taylor, 1978; p. 22). In 1943, the CMA recommended integrated health centres, with general practitioners, consultants, nurses and other health care providers (ibid. p. 29). However, professional enthusiasm for such measures waned in light of the post-war boom and the arrival of comprehensive private medical insurance schemes.

73 It is important to note that regionalization and reform of payment for primary care services bear a contingent relationship to one another. While the current fee-for-service system is fragmented and disorganized, changing the method of physician remuneration alone will not be sufficient for achieving improvements in health care. However, the introduction of population-based funding for primary care presents an opportunity to reorganize care delivery and integrate family physicians into an organized system of care with defined goals. This approach aligns well with regionalization initiatives. (ACHS 1995; p. 8). It was just this alignment that the BCMA was desperate to avoid.
One key reason for the stability of the sub-sector is the fact that medical insurance policy remained in the hands of the closed community of medical insurance plan and BCMA officials. For that reason, even with all the political spillover regarding the amounts of money made available, policy was limited to modifying the excesses of, and mitigating the effects of contradictions in, the medical care system (Hall, 1993). The terms of the debate were bounded by the size of the allocation government was able to make to the sub-sector. Issues under consideration reduced to amounts spent; they did not extend to the purposes for the expenditure.

The situation did, however, include some destabilizing elements. Government efforts to cap total funding created incentives for competition amongst doctors. Setting relative values for fees under financial caps was a politically fraught exercise. Old rivalries between specialties and between specialists and general practitioners were exacerbated by expenditure controls. The BCMA faced the threat of internal fragmentation and a revolt of the rank-and-file (Katz, Lomas and Welch, 1997; Barer et al., 1996).

A significant outcome of capping was a rising level of politicization of the sub-sector. The late 1990’s showed a reversion to job action by doctors over their remuneration. The BCMA also stepped up its media campaign over alleged under-funding, focusing on wait-lists for cancer and heart disease treatments.

In an important way, the renewed politicization showed how little anything actually changed. The disputes were plainly about resources, not the nature or significance of medical services. That debate over the availability of diagnostic and treatment services was no different from the one provoked in the 1970’s by the first round of limits on public expenditures on medical and hospital services. It was not about health care policy, but only how much money should be spent on services provided by doctors.

Barer et al. (1996) argued that the BCMA lost some ground over the issue of economic autonomy. However, there is no evidence that medical care insurance caused any major movement on the four fronts identified by Mechanic (1994) and Friedson (1994) as the boundaries of medical ideology and power. The four fronts are: (1) mode of remuneration; (2) public accountability; (3) consumer rights; and (4) dominance over other providers.

With regard to the first, remuneration, fee-for-service was actually more deeply entrenched in 1998 - five years into the reform process and thirty years into medical care insurance - than it was in 1968. Institutional entrenchment began with the 1968 introduction in B.C. of medical care insurance and was re-invigorated by the 1992 legislation and the subsequent BCMA/government agreements. With regard to the

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74 Contradictions include the perverse incentives embedded in fee-for-service medicine and the related role conflict between physician-as-advocate and physician-as-contractor. Mitigation includes regulatory oversight and mechanisms such as clinical guidelines.
75 See, as examples, the major features in the Vancouver Sun (March 21, 1998; A23; August 8, 1998, A21; January 14, 1999, A1) and the Kelowna Capital News (March 15, 1998, A3, A4, A5 and B1).
76 The threat to the role of physicians’ services and medical organization had, as a result of the accord with the BCMA, significantly receded.
second, public accountability, legislation establishing the terms and conditions of professional self-governance underwent, between 1968 and 1998, only modest changes intended to improve public oversight. Over the thirty years of medical care insurance there were minor changes in health professions' legislation, but no systematic rollback of the powers and prerogatives of any of the professions.\textsuperscript{77}

While freedom of information and human rights legislation introduced over the thirty-year period improved public access to information, thereby modestly advancing consumer rights, there was no significant impact on the private practice of medicine.\textsuperscript{78} Arguably, courts took a broader view of negligence and were more likely by the 1990's to find on behalf of patients. But that too was a very limited development in Canada (in contrast to the U.S.).

Physicians' scope of practice remained as broad and as well protected legally in 1998 as they were in 1968. Incursions and exceptions (such as the growth in privately financed "alternative care providers" and the legal creation of limited independent practices of acupuncture and midwifery)\textsuperscript{79} were kept very much at the margins. In fact, fewer conventional non-medical practitioners (i.e. excluding from consideration herbalists, acupuncturists, aroma therapists and the like) could maintain independent publicly funded practices by the late 1990's than previously, due to Medical Services Plan cutbacks on health care insurance coverage for physiotherapists, occupational therapists and other non-medical practitioners.

In sum, there is little evidence to suggest medical hegemony diminished in B.C. as the result of the operation of public medical insurance \textit{per se}. Later the study will consider the question of whether regionalization under the \textit{Better Teamwork} policy diminished the power of physicians and managers (Chapter 7). Chapter 7 will also examine how clinical guidelines and regionalization affected the role of, and distribution of resources to, medical services.

\textsuperscript{77} Perversely, even where medical professions' legislation was significantly amended to improve accountability (Ontario, of example) the evidence suggests that physicians are less likely to be held to account for unprofessional acts in 1999 than they were prior to the reforms. See Foss and Taylor (1999).

\textsuperscript{78} Neither freedom of information nor human rights legislation extended to private medical practices. The consumer protections extend only to the public sector. However, a 1992 Supreme Court decision forced broader access to patients' hospital records (\textit{McInerney v. MacDonald}, SCC 1992). Also in 1992, the B.C. government amended the Ombudsman's Act to broaden powers to act on complaints against hospitals and professional governing bodies (\textit{Ombudsman's Act}: RSBC 1979, c.306, section 35(26)). Those provisions came into force in 1993.

\textsuperscript{79} On November 18, 1994 the \textit{Health Professions Bulletin} (vol.2, no. 2, 1994) announced Cabinet's decision to designate midwifery as a health profession under the Health Professions' Act. This was a surprising decision because midwives did not meet the designation criteria of the Act. B.C. midwives were not numerous enough to be self-governing or financially independent. The move by government was clearly politically motivated – a signal to women voters that the NDP had not forgotten them and a signal to doctors that government could and would unilaterally alter rights of practice. The political nature of the decision became even more obvious when the government set a fee for midwives' services that exceeded the one paid to physicians. Nothing in the decision could be related to "community health" or \textit{New Directions} or to principles of service integration. In short, the decision was "purely political".
3.3 Frames and Institutions: Regionalization

This section begins with the principle of integration of health services within a given geographical area. Discussion then turns to the scope of services. Devolution is covered later in a separate section.

Regionalization refers to organizing the delivery of some range of services on a geographic basis. It involves coordinating the management of a defined cluster of services over a defined geographic area. Its scope might be narrow; only acute-care hospital services might be brought under a coordinated management structure for a defined locality. Its scope might be considerably broader; all publicly funded health services within a defined locality might be brought under a common management framework. Generally speaking, regionalization "involves both decentralization of authority from the central organization and centralization of authority from local institutions" (BCMA, 1994; p. 1).

Regionalization allows considerable scope regarding how the services are actually managed. The management form may be highly centralized or relatively devolved within the region. Regionalization may extend only to planning functions or it may extend to an organizational form that is fully integrated, either horizontally or vertically. Likewise, the regional management body itself might be quite autonomous from the government that created it — i.e. enjoy a high degree of devolution. Alternatively, it might be closely monitored by, and held strictly accountable to, the government. In short, a strategy of regionalization allows considerable latitude regarding the scope of services to be integrated, the degree of integration, as well as the amount of autonomy the regional body has vis-à-vis the central authority.

Regionalization of provincially funded health care services is not a new theme. Various forms of regionalization have been repeatedly recommended for, and in some cases implemented in, Canadian provincial health care systems. As early as 1964, the Royal Commission on Health Services recommended a regional approach to planning and managing provincial hospital and medical care systems (Hall Commission, 1964). By 1969, the Task Force on the Cost of Health Services was arguing that area-wide or regional planning for health facilities and services was the only viable, effective approach. Regionalization was required if integrated and balanced health care systems were to be achieved (Task Force Report, 1969).
In Quebec, the 1971 Castonguay-Nepveu Report proposed integrating health and social services on a geographic basis under the governance of regional councils (Castonguay, 1971). Shortly after the report’s release, Castonguay became the provincial health minister and the Quebec government set about creating the regional health bodies. The Quebec example spurred the other provincial health ministers to call for a national task force on the viability, costs and benefits of establishing community health centres. The task force reported in 1972, and endorsed a model of health service delivery based on multipurpose, interdisciplinary health centres serving geographically defined areas, and governed by community boards. Meanwhile, in British Columbia, the Report on the Health Security of British Columbians likewise recommended integrating primary care, public health, and social services at the community level (Foulkes, 1973).

In the United States, regional hospital planning bodies and community health centres (generally targeted at specific populations rather than geographically defined areas) were under active development throughout the 1970’s (Morone and Marmor, 1981). Overseas, the United Kingdom began a series of reforms directed at strengthening regional management of, and local accountability in, the National Health Service (Ham, 1992; Klein, 1995a). In health care delivery, as in most matters, Canadian provincial governments kept a close watch, not only on each other, but also on American and British developments.

In British Columbia, some publicly funded health care delivery programmes were organized along regional lines from an early date. Geographically defined public health districts were formed from 1928 onwards, and cost-control pressures in the 1970’s led the provincial government to organize regional hospital districts. The former, public health districts, were an administratively convenient way to deliver such state services as immunization and public health inspections. Each had its own management structure headed by the medical officer, who in turn reported to the Ministry of Health in Victoria. The districts, while providing for input by local government officials through the Union Boards of Health, did not enjoy devolved powers. Rather, they were part of the hierarchical structure of the provincial health bureaucracy.

The latter, regional hospital districts, were means for engaging municipal governments in planning the development of, and raising property taxes to support, local hospital capital construction projects. Under provincial policy, local governments needed to raise 40% of the capital construction costs for health care facilities in their geographic region. The main role of the district councils was setting capital project priorities and budgets. Because the core issue was taxation, the regional hospital district boundaries matched local government boundaries, not public health district ones.

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80 See Sidney Lee (1979) for an excellent review of health care reform in Quebec.
81 The South Okanagan Health Unit was the first public health region to organize formally.
82 Large metropolitan areas managed public health programmes through their municipal governments. The Greater Vancouver Regional District (GVRD) is an example.
The third form of regionalization of health services came in the form of the Continuing Care Division – the integration of long term nursing home, facility-based extended care, and home care. The British Columbia Continuing Care Division of the Ministry of Health was formed in 1977, and brought together community and facility-based services for long-term care patients. The programme was delivered through regional offices, based on the existing public health districts. Like public health, Continuing Care was an integral part of the Ministry of Health bureaucracy. The regional managers reported directly to regional care coordinators in Victoria.

Foulkes’ 1973 recommendation to integrate hospital, public health, primary health care services, and social services at the regional level, was never fully implemented. The short-lived NDP government of Premier Dave Barrett managed to establish some regional and community resource boards, but the initiative was wound-up by the Social Credit government that replaced it in 1975.83

Prior to the 1993 reform, health services regionalization remained limited to hospital (capital only), public health and continuing care services. Significantly, the purposes, mandates and boundaries of each of these forms of regionalization were different. Health sub-sectors each evolved independently, and even where they were integrated into the Ministry of Health, the institutional form of that integration was different and independent of the others (e.g. Continuing Care, Hospital Services, Medical Services Plan and Community Health Services were all independent divisions within the ministry).

The Hospital Services Division did not deliver any hospital services. It was a funding and regulatory arm of the ministry. With the exceptions of the provincially managed mental health and cancer treatment centres, hospitals operated as private corporations, reporting to their own boards of trustees. Joint planning was limited to raising capital for construction projects. In the late 1970’s and 1980’s, the ministry of health fostered a modest degree of integration and shared-services through financial incentives and sanctions built into the ministry’s approach to global funding of public hospitals. Inter-agency cooperation, however, remained at a low level.

Likewise, Continuing Care provided few services in the long-term care sub-sector directly. Instead, it dealt with a mix of privately operated long-term care facilities, private for-profit and voluntary non-profit agencies, private-practice physiotherapists and occupational therapists, state-employed nurses, and public health employees. The main role of the Division was to assess clients and wait-list them for suitable services, which Continuing Care then coordinated and paid for. Since it was a province-wide system (albeit administered at the regional level), a patient occupying an acute care bed in one community and assessed as requiring nursing home care might be placed in the first available nursing home bed which could be in another community. Queuing and matching patients with the first available provincially funded resource reflected the

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83 For a discussion of the regional and community resource boards, see Michael Clague, et.al. (1984) Reforming Human Services: the experience of the community health resource boards in B.C. Small remnants of the regionalization initiative survived in the isolated Queen Charlotte Islands and the northern resource-extraction town of Tumbler Ridge.
primary mandate of Continuing Care – to control costs by relieving pressure on hospital beds.

The inconsistent organizational principles informing the British Columbia health care system, in particular the structural separation of long-term care and home support services from hospital services, were unhelpful in attaining Continuing Care’s mandate to reduce bed costs through moving patients from acute care facilities to cheaper alternatives. The heart of the problem was the fact that the Ministry of Health, in general, and Continuing Care in particular, had no direct influence over hospitals beyond the ministry’s crude tool of global funding allocations.

The duplication, confusion and inefficiency involved in running a decentralized hospital system in parallel to a centralized long-term care one was finally addressed in the Victoria Health Project (Victoria Health Project, 1988). The objective of the project was to synchronize the acute and long-term care sub-sectors. By 1990, the Ministry of Health concluded that the Victoria Health Project showed savings could be made through more effective integration of Continuing Care and public hospitals at the regional level (Victoria Health Project, 1990). That conclusion gave a major impetus to the broader reform of bringing together hospitals, long-term care and public health into a common management structure at the regional level.

By 1990 regionalization had surfaced on the policy agenda of virtually every OECD country (Mills et al., 1990). That was partly true for reasons related to improving the performance of publicly funded services under conditions of rising public debt. Those reasons include:

- reducing service fragmentation
- identifying and closing service gaps
- reducing duplication
- achieving efficiencies of scale by merging managerial, administrative and support services
- improving the quality of communication and information, and
- enhancing accountability and responsiveness.

Regionalization is, in this sense, an approach to rationalization. Services and structures are centralized and rationalized over a defined geographical area to improve efficiency.

But regionalization had become attractive internationally not only because of the pressure on governments in the capitalist democracies to improve the quality and cost performance of public services during the economic downturn that followed the 1973 global economic crisis. The power of the idea of regionalization was at least partly due to its ideological linkages. Stripping layers out of existing organizations, improving responsiveness to customers, forging partnerships, breaking down traditional bureaucracies, and spinning-

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84 It was also controversial. The BCMA (1994; p. 20) argued that the Victoria Health Project was never evaluated in terms of cost-benefit or outcomes for patients. This is no surprise. Studies in the United States “have failed to support the contention that integration leads to economies of scale, greater efficiency in service delivery, or improved patient outcomes” (Church and Barker, 1998; p. 473).
off services from central government to autonomous or quasi-autonomous bodies were central aims of what became known as “new-right thinking”, especially in the form adopted by Margaret Thatcher’s governments in the United Kingdom (Savoie, 1994). Regionalization owed part of its attractiveness to governments as a tool to those ends.

Governments on the right, such as the ones in power in the U.K. and New Zealand, saw regionalization as an approach that facilitated opening public services up to market forces (Seedhouse, 1995). Governments on the left, such as the one that came to power in British Columbia in 1991, saw regionalization as an approach that could improve responsiveness to the public through political forces – i.e. devolution to elected local authorities. Governments on the right regarded regionalization as a means of improving the accountability of suppliers to consumers; governments on the left regarded it as a means of improving the accountability of providers to the public. Both left and right wing politicians regarded regionalization as a means of distancing themselves from difficult and contentious health sector cost-control measures (Purchase and Hirshhorn, 1994).

Given that regionalization of public services in general, and health services in particular, were significant themes for nearly thirty years, the question obviously arises as to why the British Columbia government attempted to act in a coordinated way in 1993 when it had failed to do so previously. The decision to act involved more than the “spirit of the times”. It also lay beyond the common occurrence of governments defining policy problems in terms of an internationally fashionable solution (Hogwood and Peters 1985).

85 The ideas comprising the ideology of the “new right” are also consonant with many of the principles espoused in the 1980’s by academic analysts of public management. Theorists who demonstrate the link include B.C. Smith, Decentralization: the Territorial Dimension of the State (London: George, Allen and Unwin, 1985) and Evert A. Lindquist, “Recent administrative reform in Canada as decentralization: who is spreading what around to whom and why?” (Canadian Public Administration, vol. 37, No. 3, pp.416-430, 1995). See also Peters and Savoie (1995) for a discussion of the impact of, and interrelationships amongst, contemporary private-sector management thinking, new-right thinking, and the emerging public policy emphases on deconcentration, regionalization, integration, and accountability of public services.
There are four clusters of framing variables related to interpretation:

(1) The perceived financial situation. The newly elected NDP government inherited in 1991 an unanticipated provincial deficit of over $2 billion. Ministry of Health data to 1990 showed health care expenditures continuing to rise faster than general inflation. Those data also showed health care consuming a growing proportion of total provincial spending. At the time, the rate of increase in spending was believed to be on the cusp of a large increase, given the demography of the province. The proportion of available provincial revenue directed to funding health care was also feared to rise given that economic growth was flat, provincial debt was mounting, and federal cost-sharing was declining.

(2) The political situation. The newly elected NDP government was only the second left-of-centre one to be elected in the history of the province and the first social democratic government elected in 20 years. Its predecessor was swept out of government after one short term. The New Democratic Party remained sensitive to the charges that it was incapable of managing the provincial economy, was a profligate spender, and would, at best, last a single term in office. “Out-of-control” health care spending was therefore something of a litmus test for the government. Also important politically was the self-image of the NDP. The New Democratic Party regarded itself as the force behind the Canadian system of publicly funded hospital and medical services. Both to succeed in a future election, and to keep party members on-side, the government needed to show it could take effective measures to protect the universal, publicly-funded health care system the party saw as its legacy to the Canadian people.

(3) The precedents. Every Canadian province except Ontario had, by 1993, embraced a form of regionalization for its health care system. The NDP government in Saskatchewan had implemented a reform based on elected regional health authorities (Hurley, Lomas, Bhatia, 1995).

(4) The Victoria Health Project. Ministry officials involved in the project concluded that savings could be achieved by integrating health care services at the regional level.

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86 The provincial government did not know until several years into the reform that health care spending plateaued before the initiative even started. Robert Evans (1997b) showed costs peaked in 1991/92, however the data demonstrating that were not available until 1997.

87 Barer, Evans, and Hertzman (1994) demonstrated both the importance of this belief for provincial health policy and the fallacy underlying it.

88 In 1977, growth in federal cost-sharing was capped; actual cuts in federal transfers were imposed in 1986/87, 1988/89 and 1989/90. The 1991 federal budget froze provincial entitlements at the 1989 level until 1995.

89 Canadian hospital and medical insurance were both pioneered by the New Democratic Party’s predecessor (then known as the Cooperative Commonwealth Federation) in the province of Saskatchewan. The federal hospital and medical care cost-sharing programmes were promoted at the national level by the federal wing of the New Democratic Party. “Preserving medicare” was part of the 1991 NDP provincial election campaign.
There is also a cluster of framing variables more explicitly linked to action – “ideological factors”.

- Whereas regionalization was generally adopted elsewhere for reasons of efficiency, the British Columbia provincial government saw regionalization (combined with a high degree of delegation to the local health authorities) as presenting an opportunity to reduce the power and authority of ministry bureaucrats, health care managers, and especially health care professionals. Authority over the provision of services could be brought “closer to home” and bureaucratic and professional barriers could be brought down through a strategy of regionalization. Those aims reflected an anti-professional and anti-bureaucratic bias -- a variety of leftist populism – as well as the influence of a community health perspective.

The first four clusters, acting together, account for why the provincial government finally acted on health care regionalization. The fifth, ideology, accounts for the peculiar form the initiative took in British Columbia – especially as it relates to the issues of devolution and accountability.

Regionalization raises the issue of the scope of services to be integrated at the regional level. The Victoria Health Project set the minimum terms as including hospitals, long-term care facilities and home care services. Initially, the government’s position was more ambitious, extending beyond hospital and long-term care to mental health services, addictions, community and public health, cancer treatment, and some allied social services. As will be demonstrated, a broad scope was consistent with, indeed was required by, the ideological framework of New Directions.

The broad scope soon narrowed. The B.C. Cancer Control Agency and Riverview Provincial Hospital, the tertiary care provincial mental health facility, lobbied strenuously for their continued independence as province-wide services. With support from ministry officials, both were severed early from the reform initiative on the putative grounds that centralized provincial tertiary cancer and mental health care would be both cheaper and more effective.

The suggestion that all hospitals be integrated under the control of a local health authority within regions ran afoul of B.C. churches which continued to operate a number of hospitals under the auspices of various ecclesiastical organizations. That led to protracted side-negotiations between the government and the coalition of churches. Ultimately an agreement was reached that left the ownership and some management rights vested with the churches.⁹⁰

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⁹⁰ An agreement was finally reached in March 1995. The Denominational Health Services Agreement guaranteed churches the rights of ownership and title, retention of their own board of trustees, and management rights. Major capital projects could be self-funded as long as the operating costs could also be funded by the sponsors. Chief executive officers could only be appointed in consultation with the governing CHC or RHB. (MOH, 1995e).
The success of the churches encouraged the boards of trustees of some of the larger public hospitals to renew their lobby against being merged with other health services at the community level. The four “peer group two” hospitals fought for exemption. The boards of those hospitals, Naniamo General, Royal Inland, Prince George Regional and the Kelowna General, had a number of motives. Amongst them was preservation of the traditions of their institutions, protection of land, assets and endowments, medical staff aspirations for new and expanded programming, and, in the case of Kelowna, preventing the introduction of abortion services.91

The hospital boards ultimately failed in resisting regionalization, but succeeded in changing its form. The resistance of the peer group two hospitals to regionalization slowed the implementation of New Directions. The ensuing delay and confusion contributed to the abandonment of New Directions and the emergence of Better Teamwork.

By the time the government was ready to devolve authority, the scope for regionalization had narrowed. The power of the tertiary care services in the Lower Mainland (essentially greater Vancouver) and the complexity of their interaction was such that the government undertook a special study of them outside the framework of New Directions (MOH, 1995).92 Tertiary cancer and mental health services would remain centralized, managed by separate provincial agencies. Pharmacare, the provincial drug programme, and medical care insurance would remain with the Ministry of Health. The social services boundary remained fuzzy and at risk of contraction since community mental health and addictions personnel (many of whom had a social work background) advocated for closer organizational links with social services.93

91 Local churches dominated the hospital society and were able to elect a number of anti-abortionists to the Board of Trustees. As a result, abortion was not an approved clinical service in the hospital. A change in governance structure would disempower the local churches and, consistent with the government’s policy, pave the way for introduction of abortion services in Kelowna.
92 The recommendations of the Vancouver Region: Acute Care and Rehabilitation Services Study (Lovelace, 1995) were controversial because the study was conducted without public consultation and focused strictly on management and efficiency issues. See supra, p. 133.
93 Public health did not see itself as part of the “fit” with acute and long-term care either. Medical Officers of Health feared submersion within a new regional bureaucracy.
3.4 Action Framing: Power and Devolution

Devolution involves an actual transfer of control and authority from a central government to another body that may then legitimately exercise independent powers over a defined sphere of activities. Devolution differs from delegation in that the former, devolution, involves a substantial degree of independence for the subsidiary body whereas the latter, delegation, is limited to delineated functions (Mills, 1993). Devolution involves revenue generating and spending powers (Mills, Vaughan, Smith and Tabibzadeh, 1990).

Devolution includes a transfer of governance authorities – the right to make policy and authorize resource allocations. The mechanisms and the rights for the creation of new policy are inherent in the policy of devolution. Devolution is not only a process of restructuring the policy delivery systems through creating new bodies, but it is also a process of transforming the policies by giving authority over policy making to those bodies.

Whereas regionalization is a common policy response to the complexities of health care delivery systems, devolution to regional bodies is not. Delegation of specific tasks such as planning and coordinating functions under central government’s regulatory oversight is the usual approach to regional health authorities. The pre-1989 National Health Service in the U.K. and the pre-1993 regionalization initiatives in Canada took the form of such limited delegations.

The reason for the avoidance of devolution as a strategy is not hard to find. Devolution is specifically intended to enhance local control. It thus threatens both the central government’s control and policy cohesion. Delegation, in contrast, maintains “policy cohesion together with central planning, control, and allocation of resources” (Collins, 1990; p. 73). It permits very little in the way of local variation on either procedures or outcomes.

Unlike delegation, devolution raises several thorny questions. The first is the legitimacy of the body to whom the powers are devolved. It is not self-evident that a body should enjoy devolved powers and act with a degree of autonomy from the (presumably legitimate) government authority that created it. Usually the problem of legitimacy is dealt with by legislating the powers of the new authorities and requiring elections for the officials exercising those powers. Canadian examples include local governments and bodies such as boards of school trustees.

The second question raised is the accountability of the devolved body to the government that created it. The central government would presumably prefer strong accountability measures, but those are hard to square with the legitimacy requirement, local elections, and accountability to the residents of the region. Accountability to government is also

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94 The notable exception was Saskatchewan (Hurley, Lomas and Bhatia, 1993). Saskatchewan did attempt a devolution of authority over health care services to elected regional bodies.
difficult to reconcile with an expansive scope of local decision making or freedom to determine local procedures.

Devolution raises the issue of regional variability. If regional authorities are to exercise a degree of independent control over their procedures and substantive decisions, it follows that both the processes and outcomes will be different across regions. That necessitates consideration of how much variability will be tolerated by the central government. It also necessitates deciding which tools such as service standards, mandated core services, and regulations will be deployed by the government to manage regional variation.\(^{95}\)

Devolution raises the issue of variability of resources. Regional authorities will be neither equally equipped with health care resources nor challenged by the same health care requirements. Some defensible mechanism for equitable funding of the regional authorities must be arrived at and a defensible means for measuring the relative health care demands (or population needs for health care services) across regions must be developed. No where to date have these mechanisms been worked out to the satisfaction of governments, health authorities, and the populations affected.

Problems of governance such as the nature of the relationship between the ministry and the new authority arise. Devolution is particularly hazardous in parliamentary democracies. Ministers have responsibility to the legislature for public programmes and public spending – a responsibility that cannot readily be devolved. It is especially difficult to define and constrain adequately the roles of the bureaucracy, the Minister and the new boards to ensure a degree of independent operation within their proper spheres of authority. A failure to define adequately those roles and relationships will predictably lead to a breakdown characterized by random, strategic interventions by the respective parties. Finally, how can the state boundary be redefined so that the government does less in the policy area it has devolved but is still able to exercise adequate control?

Devolution also pushes ideas, cultures and norms to the forefront. “While governments may be successful in changing the organizational structures, they must also overcome the dominant way of thinking and supplant this with a new corporate culture” (Church and Barker, 1998; p. 475). Community health, continuing care and acute care organizations had very different mindsets; their organizations had different histories, practices and norms. They were cross-cut by other organizations – a variety of unions and professional associations – which also had organizational histories, norms and power relations. In B.C. prior to regionalization, none of the service delivery or provider organizations subscribed to the “community health” frame. Past cooperation was limited and guarded. Most health service institutions embedded traditional antipathies.

\(^{95}\) A related problem is how to prevent transfer of costs from one region to another. That may be inadvertent (through referral patterns or patient choices) or deliberate (through externalization of costs).
Given the problems inherent in a devolutionary strategy, the decision by the B.C. provincial government to embark upon it is remarkable. It clearly requires explanation. Plausible elements in such an explanation are:

- a political ideology committing the government to a strategy of community control;

- adoption of a policy strategy designed to undercut the power and predicted resistance of the existing policy community;

- a health policy perspective that required community control over locally provided services and the resources used to deliver them;

- idiosyncratic factors such as the recruitment of Saskatchewan’s past-deputy minister to the B.C. Ministry of Health, the personality and inclinations of the Minister of Health and the Premier, and the political naiveté of the NDP government;

- the role of rhetoric – i.e. use of the language of devolution to disempower and delegitimize health care professionals, without real intent on the part of government to meaningfully transfer authority to health authorities.

All of these candidates (except idiosyncratic factors) will be explored as the ideological dimensions of the health reform policy are examined in the following sections. A complicating factor is that none of the candidates excludes any of the others, and that different factor(s) may have been decisive for different key actors at different times in different contexts as the policy was developed and implemented.

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96 Idiosyncratic factors are, by their nature, non-researchable. They function as residual explanations when there appear to be no other compelling reasons.
3.5 Policy Formulation: Report of the B.C. Royal Commission on Health Care and Costs

The Report of the B.C. Royal Commission on Health Care and Costs (the "Seaton Commission Report") diagnosed the B.C. health care system as suffering from fragmentation, lack of coordination, structural barriers to change, and vested interests tenaciously clinging to their respective portions of public expenditure. After summarizing expenditure trends, the Commission concluded: “that in a zero growth environment, each program has managed to hold onto its share. In the Chinese idiom, each group of providers has received an unbreakable iron bowl” (Seaton, 1991a; p. 11, emphasis in the original). In that respect, the Seaton Commission echoed the findings of a Royal Commission conducted twenty years earlier. “In the existing non-system, the consumer has been ignored, while the vested interests of the medical profession, the institutions, and the central bureaucracy, have been emphasized” (Foulkes, 1973; pp. 313-14). 97

The major recommendations of the Seaton Commission were derived from that diagnosis. Chief amongst them were 98:

- develop health goals and health status indicators for the province
- establish a Provincial Health Council reporting directly to the provincial legislature (Seaton, 1991, b; p. A-16)
- provide for greater autonomy of the provincial health officer to review and comment on the health of British Columbians and on the health impact of various public services (Seaton, 1991b; p. B-8)
- improve management information systems thereby making it possible to know if the public expenditures are achieving the desired results (Seaton, 1991, b; p. B-22, B-104, C-122, C-140 and C-141)
- constrain the proliferation of technology through more rigorous evaluation of its effectiveness prior to its diffusion (Seaton, 1991, b; B-25)
- improve the accountability of health care service providers by strengthening public oversight, specifying expected outcomes, and enhancing the transparency of health provider activities through public access to information and more effective

97 This is an apt demonstration of how little had changed over the intervening years.
98 The Seaton Commission also made a large number of recommendations regarding specific services, regional disparities, and the special requirements of aboriginal peoples and ethnic minorities.
complaints procedures.\textsuperscript{99} (Seaton, 1991b; p. B-22, B-26, B-28, B-29 and B-23)

- continue to constrain hospital expenditures and reduce acute care beds in operation (Seaton, 1991b; B-96)

- cap fees paid to medical practitioners by setting a global limit on expenditures (Seaton, 1991b; B-90, D-8)

- transfer savings made through constraints on hospital and medical spending to facility and home-based long term care (Seaton, 1991b; p. B-97)


The recommendations were undergirded by an assumption that there was adequate total public funding for the health care sector.\textsuperscript{100} Consequently, access problems and apparent under supply of health care providers were construed by the Commission as management problems. In the Commission’s view, adequate aggregate resources were mal-distributed due to organizational factors that in turn reflected perverse incentives associated with prevailing payment mechanisms and professional privileges. Like the inquiries conducted under the conservative governments in Britain and New Zealand, the Seaton Commission found the system needed more management, not more money.

None of the specific recommendations or findings was surprising. The general lines of argument were consistent with other provincial inquiries into the health sector, and the recommendations that had been made at Federal-Provincial Conferences of Health Ministers over the preceding decade. Only the tone was unusual. Other provincial reports were less explicitly adversarial towards health care professionals.\textsuperscript{101} However, even that element was in keeping with British Columbia’s traditions. The same tone was evident in the 1973 commission report.

It is important to note that the Seaton Commission Report took a conventional view of health services as those publicly funded health care services provided to individuals. While the report supported placing more emphasis on public health and health promotional activities, it did so from the perspective of influencing the factors that have an impact on the health of individuals. There is no evidence of a “community health

\textsuperscript{99} “Often the people responsible for overseeing the colleges and associations set up by [professional governance] acts demonstrate a profound misunderstanding of the distinction between protecting the public and protecting their own interests. If the health care system in BC is going to change, then the acts governing the health care professions must change as well” (Seaton, 1991a, p. 38).

\textsuperscript{100} More precisely, the Commission’s view was that evidence could not be adduced to demonstrate under funding, in spite of the perception of physicians and a significant segment of the public. B.C. fell within international and Canadian norms for health care funding. No sense could be made of wait lists and wait times due to the poor quality of the data.

\textsuperscript{101} Compare the Seaton Report with, for example, the Rainbow Report from neighbouring Alberta (Rainbow Report, 1989). Seaton focuses on the “iron rice bowls” and lack of professional accountability. The Rainbow Report focuses on organizational and funding issues in health care delivery.
perspective”. That is, the report was not about the capacity of communities to configure themselves in such a way as to support the wellbeing of their members. The perspective of the report was firmly grounded on the individual – the patient or prospective patient – not the health and welfare of a community of citizens. To the extent that the Report concerned itself with the health of populations, the reference is to aggregations of individuals, not communities.\(^\text{102}\)

The orientation of the report is not surprising given the Commission’s mandate, its composition, and the principle it chose to base its report upon. The report was structured as a defense of the principles of hospital and medical insurance. Its object was to mitigate contradictions that the system based upon those principles generated. The Commission was not set up to reform the health sector, but to find fixes for some of its abuses. The current publicly funded health care system would be maintained, only rendered more productive. Thus the managerial nature of the recommendations flowed naturally from the purpose the Commission was to serve.\(^\text{103}\)

The Seaton Commission report was published under the title “Closer to Home”. Curiously, however, the use of the expression in the report was ambiguous, and did not, contrary to what the government and health reform advocates later claimed, mean community control over the provision of local health services.

“Closer to home” was defined as “medically necessary services provided in, or as near to, the patient’s place of residence as is consistent with quality and cost-effective health care” (Seaton, 1991a; p.6). It reflected the briefs and personal presentations by rural British Columbians who were deeply concerned over their limited access to medical and hospital services. It was closely connected with the long-standing problem of underutilized rural hospitals and the difficulties of recruiting and retaining medical practitioners in remote communities.

Despite the high profile of the problem, a mere six pages of the final report (Seaton, 1991b; B-58 to B-64) dealt with the issues of health care services in rural and remote communities. Those pages were in response to three hundred and eighty briefs from rural residents complaining of poor access to necessary medical services (ibid.; B-57). While the recommendations included some measures to make rural medical practice more viable, they also included recommendations to close the rural hospitals (ibid.; B-63) and improve travel subsidies rather than attempt to locate services in every community (ibid.; B-64).

\(^{102}\) In one place, the Report appears to reference collectivities rather than individuals. “It is time to recapture the public component of public health and stop the drift toward the American system of care with its focus on the individual rather than the public good” (1991a; p. 13). The comment, however, seems to be in the context of a line of argument that people should get what they need from a health care system, not what they want. That is consistent with a medical perspective on health care services, rather than a community health one.

\(^{103}\) The Terms of Reference for the Seaton Commission, established by the centre-right social credit government of Bill Vander Zalm, called for an examination of the organization and management of the current health care system with a view to maintaining access and affordability (Seaton, 1991b; iii). They did not call for a re-thinking of provincial health policy.
The theme of the report was certainly not to disaggregate services and spin them off to smaller population centres. On the contrary, the report had a centralist theme – concentrate and integrate services to improve their efficiency.

“Closer to home”, besides its rhetorical value, meant something quite different from service delivery at the local level. It meant removing services conventionally provided in hospitals and relocating them to less costly delivery venues such as long-term care facilities or in-home care. The latter, home care, is obviously “closer to home”; the former may or may not be depending on the respective location of the acute and long-term care facilities.

Removing services from hospitals and relocating them to less expensive venues was the problem around which the Seaton Report turned. Given the fact that B.C. hospitals had a very high utilization rate and therefore no surplus capacity, solutions had to come from two directions. Patients who should not have been admitted had to be identified and directed elsewhere. Patients who no longer needed the unique resources of the hospital also had to be identified and discharged. Both directions assumed the existing hospital population was inappropriate. Both directions required that alternative services be made available.

The Seaton Commission assumed, without offering evidence, that the hospitals in aggregate were spending at least as much money on caring for patients who did not need hospital services as it would cost to provide appropriate services in alternative facilities or through home care. The Commissioners also assumed, without benefit of evidence, that there was no population of persons needing hospital services that would fill the beds vacated by those who did not. A stricter management of admissions would reduce and keep low the flow of patients into the hospital sector; strict management of discharges would ensure adequate capacity for that inflow. On those assumptions, and only on those assumptions, could the Commission have concluded, as it did, that the money to pay for long-term care could be obtained through cuts to hospitals (ibid.; B-97).

More effective management of the very expensive provincial resources represented by acute care hospitals can free up funds for continuing care and other needed health care programs. But it must be understood – and this cannot be avoided – such an approach implies fewer jobs in hospitals.

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104 The Commission did not explain how the transition would be managed. Presumably to start the process, new money must be invested to create capacity in the alternative care sector. Long-term care facilities and home care were already wait-listed in 1991, which was the main reason why patients backed-up in the hospitals. Further, that back up entailed savings. Sicker patients could not be admitted, some elective surgeries could not be performed, and nursing staff could be kept at skeletal levels because many in-patients were not acutely ill.
Furthermore, since a primary motivation for reducing the size of hospitals is to transfer resources to other health care programs, it would be highly inappropriate for all the savings won through this downsizing to be absorbed in improvements in the relative earnings, benefits, and working conditions of hospital workers (ibid.; B-96).

The proposal to transfer resources from the hospital and medical sub-sectors to nursing homes and home care services gave rise to concerns in some quarters. Medical and hospital services are (at least partially) protected by the financial penalties the federal government can impose on provinces that allow cost-shifting to patients. The provisions of the Canada Health Act do not, however, extend beyond the core medical and hospital insured services simply because the federal government does not share in the cost of their delivery. Indeed, one of the principal reasons why those community services are cheaper to provide than hospital services is that room and board, drugs and other charges are borne by the patient or her family in the case of community services, whereas all costs are insured by the provincial health care plan in the case of hospital services. (The other principal factor is lower wages in the community health sector.) Shorter lengths of stay in hospital and decreased admissions translate directly into higher financial and care burdens for patients, their families and the community. Transferring more care to the community may, in effect, shrink the scope of publicly insured services.

“Closer to home”, then, had little to do with providing a range of publicly funded services closer to the place of residence of the recipient. Instead, it was primarily about moving services out of hospitals and into alternative care settings. It was not a strategy for strengthening the community or fostering community health, but rather a strategy for reducing the cost of the provision of health care services to patients.

“Closer to home” later became a catch phrase not only for alternative health care services, but also for regionalization. This is rather surprising since the position the Seaton Commission took on regionalization was soft and ambiguous. The Commission

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105 The latter part of the quoted text demonstrates how the Seaton Commission construed resource flows within the various health sub-sectors as reflecting the material interests of health care providers. Unless deliberately and authoritatively channeled elsewhere, the funds would continue to flow to the same parties. The iron rice bowls would remain unbroken.

106 See, for example, Deber (1997) who argued such a transfer is simply a transfer of costs to patients and their families. She further argued that continuing care services are outside the protection of the Canada Health Act, and therefore subject to user charges, reductions in service levels and the like. The transfer of care from hospitals to the community is actually cover for the transfer of costs from the taxpayer to the user.

107 Since the 1970’s, various provincial and federal-provincial reports have advocated home care as a strategy to reduce health care costs. However, provincial uptake has been modest and uneven, largely because most provincial governments do not believe the “hospital substitution” argument and fear home care would be a simple add-on to existing services and costs. The evidence on the matter remains poor. It is not clear that either patients or their family care givers prefer home care, in spite of the rhetoric of home care advocates. Further, the home circumstances of most people who require care (the poor, the disabled, the frail elderly) are not conducive to its provision. Finally, the clinical evidence is mixed — some patients seem to do better at home, others worse. See Peter Coyte (1999). The Ministers of Health did not commission a thorough study of these questions until 1998. That report is due by 2000.
recommended a degree of deconcentration of Ministry of Health services, but did not believe line and managerial staff needed to be relocated from the centre to geographic regions (Seaton, 1991b; B-37). Further, the Commission did not provide a clear idea of the scope of regionalization. It appeared the Commission was recommending closer integration of Continuing Care and Public Health with hospital services at the regional level, but the proposals lacked specificity.

It was clear that the Commission did not envisage devolution to regional health authorities. On the contrary, the Seaton Report recommended a hierarchical reporting structure based on Ministry of Health regional managers (ibid.; B-37, B-38). Under the recommended model, central ministry staff would remain responsible for policy, overall goals, action plans and evaluation (ibid.; B-37). They would also set the spending targets for regional managers (ibid.; B-39). Local input would be limited to citizen advisory committees (Seaton, 1991a; p.6). In short, the approach reflected principles of the new public management – deconcentration, delayering, integration, enhanced control from the centre, improved information, and consultation with clients. It did not reflect principles of community empowerment, citizen control, and community health.

Service integration was crucial. But again, the position taken by the Commission was soft and ambiguous. It was clear that the Commission believed services were fragmented and inefficient. It was also clear that the Commission believed that fragmentation adversely affected patients' abilities to access the services they needed. Vertical line management from the ministry created boundaries and barriers rather than the desired "seamless services" (Seaton, 1991b; B-40). However, the actual recommendation that emerged was for the ministry to explore prospects for a matrix organization, with cross-programme teams to facilitate coordination (ibid.; B-40, B-41). Further, "the commission recommends that hospital boards retain their current autonomy" (ibid.; B-44).

The general point to be drawn is the recommended policy responses all took the form of conventional governing tools of incentives and regulations – "instruments and their settings" in Hall’s terms. The critical element from the Seaton Commission’s point of view was central control, which in turn depended on information. The most daunting challenge was the development of information systems that allowed decision-makers to know what was actually happening in the health care system, whether it was the application of technology or the consequences of other actions of health care providers. The flow of information and the organizational forms that facilitated or impeded that flow took central stage. That is not surprising because of the public choice perspective that informs new public management.\(^{108}\)

\(^{108}\) The public choice perspective of welfare economics and modern public administration is grounded in a model of rational actors pursuing their material interests in a context of limited information. Information itself is a key resource. Both increased regulation and increased reliance on markets require increased information in contrast with strategies of devolution and shared governance which are relatively less information intensive and based on grounds for cooperation other than incentives. See Tuohy (1999) on the relative dependence of approaches on information. See Jachtenfuchs (1996) on underlying conceptions of rationality.
This was a perspective the unions and the professions understood but did not much like. It was, as shall be shown in the section on New Directions implementation, consistent with both the medical and union frames of reference, only drew different conclusions because the empirical assumptions were different. However, the Seaton Commission perspective was not the perspective of New Directions. Not only did the government's policy when it was finally announced depart from Seaton's recommendations, but also the ideologies underlying the two policy statements were irreconcilable. One major theme connects them, however. Both policy statements claimed the existing system operates to the material benefit of health care providers and to the detriment of taxpayers. The significant difference was how that power was conceived of, and thus how policy was designed to counter it.
CHAPTER IV: New Directions

4.1 New Directions: Policy Overview

New Directions, as a policy initiative, had four elements. The first was the policy announcement itself, New Directions for a Healthy British Columbia (MOH, 1993a); the second was A Guide for Developing Community Health Councils and Regional Health Boards (MOH, 1993b); the third was Our Understanding of Health (MOH, 1993c); and the final element was Bill 45, the Health Authorities Act (MOH, 1993d). As would be expected with any government policy statement, New Directions contained ambiguities and some apparent contradictions. It appealed to three constituencies: organized labour, health reform advocates and the general public. Like the Seaton Commission Report, the New Directions documents portrayed health care professionals and bureaucrats negatively. They were clearly the objects of reform.

Ambiguities included a lack of clarity regarding “health” and the “health system”. Neither were defined or even described. Sometimes documents referred to communities and their empowerment, sometimes to factors such as nutrition, housing and sanitation, sometimes to lifestyle factors, and sometimes to health care services, without apparent regard for the implications of different views of health and its determinants. “Health services” ranged in scope from everything that could impact on community and personal wellness down to the traditional Ministry of Health package of hospital, continuing care and public health services.

Apparent contradictions included connecting a commitment to the principles of universal, comprehensive medical and hospital insurance to broader commitments regarding comprehensiveness, integration, equity, access, and improved population health in a context of limiting spending on medical and hospital insurance. Nowhere did the documents address how individual entitlement to choice of service and service provider, the central principle of medicare, could be squared with collective health goals and cost-containment.

Yet taken as a piece the perspective of New Directions was very clear. The intent was to devolve substantial power to citizens at the community level, not only to counter the power of the health professional elites, but also to foster a community orientation to wellness. The explicit intent was to build a constituency of support behind a broader concept of health, thereby engaging the local authorities in reforming not only health care services, but also the social and economic conditions that prevailed in their communities. Another explicit direction was the extension of additional power and privileges to unionized health care workers.

109 Those ambiguities and contradictions reflect the strategic, symbolic and substantive purposes of policy (Marjone, 1989; Stone, 1988), as well as authorship by committee.
While seemingly incongruous, in the context of the policy the pro-union stance made sense. First, labour unrest would derail the reform process and likely lead to the defeat of the government before the initiative could be institutionalized. Second, the unions were strong supporters of the government’s position (in opposition to organized medicine) to limit any further private financing of medical and hospital services. Unions and government were at one in opposing a “two-tier” system whereby private services ran in parallel with publicly funded ones. Third, nursing, represented by one of the largest and most powerful unions, sought an expanded role in primary care and community services. Many nurses were also advocates of restrictions on medical power, as well as advocates for health promotion and health education (at least in so far as those activities employed nurses). Nurses were therefore the strongest natural allies in the reform process, even though their interests diverged from government over protection of hospital sub-sector jobs. The divergence of interest, however, marked a divergence in perspective or ideology as well. The union perspective, as will be shown later in the chapter, diverged sharply from New Directions – a point that became especially salient over the issues of the role of community health councils and (in the case of the BC Nurses’ Union) the election of council members.

Again, stepping back and looking at the policy as a whole, it showed remarkable congruence with Light’s ideal type of “community health”. The emphasis was on developing “with others priorities and programs” that improve health (Light, 1997, p.111). The individual was construed in New Directions as “an active, self-responsible, informed member of the community” (ibid.), not a patient, client or a dependant of state-provided services. Power was to be decentralized; in the New Directions policy framework both the state and the medical profession would be weakened (ibid.). Key institutions would be community boards. Ties would be actively forged with other programmes and institutions. The philosophy was egalitarian and participatory (ibid.).

From New Directions’ perspective, the community should be responsible for, and be granted the power to, develop in accordance with its own needs and values. Democratic community development was linked to the idea that an active citizenry combined with collaboration amongst institutional actors would foster a healthy community, which in turn would provide the social and economic environment necessary for healthy individuals. Happily, circumstances would also be created whereby health care services would be seen as essential, but not the dominant elements within health services and

110 This is an important point of congruence with Light’s prototypes, infra. p.54. Both the unions and the state support a single payer, publicly administered system, but for different reasons. The former finds it easier to organize workers and conclude favourable collective agreements. The latter find it easier to control aggregate costs.

111 The conflict of interests could be kept submerged because both sides thought the expansion of long-term care and home care would absorb displaced acute care nurses. This was a naive assumption that conflicts with the philosophy and practice of community care. Acute care nurses, especially diploma prepared ones, were neither trained nor socialized to work effectively with chronically ill and disabled people in community contexts. Academic preparation proved to be a major bone of contention between the Registered Nurses’ Association of B.C. who argued that nurses needed a degree to work in the community and the BCNU who claimed only a diploma was necessary.
health related activities. Those circumstances would encourage a mindset of parsimony with regard to health care.

The ideas of *New Directions* were bolstered by supportive institutions. The Community Health Council/Regional Health Board (CHC/RHB) model would force community accountability and responsiveness, as well as inter-sectoral and inter-community collaboration. The former would be achieved through integration of a broad range of services at the community level under the control of the CHC; the latter by requiring community plans and expenditures to be vetted by representatives of all of the communities within the region (RHB). Local governments were mandated partners through legislated representation on CHCs.

In a nutshell, that was the policy first announced in February, 1993. As the study will show, within a year it had been dramatically altered. In just over three years, it was gone, replaced by a policy that reflected the perspective and findings of the Seaton Commission, rather than the ideology of the first-term New Democratic Party. Gone with it was the attempt to articulate a community health perspective. Also gone were the institutions (CHCs) and mechanisms (elections, taxation powers, and broad scope of authority) that would have provided the organizational support for the health reform policy.

4.2 Policy Elements

4.2.1 Ministerial Statement

The ministerial statement *New Directions for a Healthy British Columbia* articulated a vision of healthy citizens living in health communities.

*Healthy citizens take personal responsibility for good health habits. They are able both financially and socially to make informed and effective decisions and choices . . . they contribute to each other’s wellbeing . . . Healthy communities are characterized by local government, business, labour, and other citizens working together to identify and resolve issues affecting health. They create supportive environments . . .*(MOH, 1993a; p. 7)

That vision was connected to a commitment to the five principles of medicare – universality, comprehensiveness, accessibility, portability and public administration – but how that commitment related to the vision was not discussed.
New Directions set out three system characteristics (responsive, comprehensive and integrated), four principles (equity, partnership, fiscal responsibility, and sensitive implementation), and five new directions (better health, greater public participation and responsibility, bringing health closer to home, respecting the care provider, and effective management). \(^{112}\) Again, there was no discussion as to how the characteristics, principles and new directions related to one another in the policy model.

The document referenced a broad range of factors affecting health and the need for a tolerant democratic polity. It also referenced “healthy public policy” – the need for all public policy making to consider the potential impacts of policy on human health. It alluded to community action. But “health” was not defined.

The first new direction was “better health”. Here the Minister committed the government to:

- A provincial health council to foster a broader perspective on health and report to the legislature on progress;
- A set of provincial health goals;
- A stronger role for the provincial health officer;
- Greater emphasis on health promotion;
- The removal of obstacles to equitable access and to equitable health status;
- A mandatory health impact assessment of proposed public policies and programmes (MOH, 1993a; pp. 12-13)

This first new direction and the commitments flowing from it accorded well with Seaton Commission recommendations, and with initiatives that had been taken elsewhere in Canada. However, as will be shown later in the chapter, the government made good on almost none of those commitments. Health goals eventually emerged, but were attenuated and ambiguous. Some changes were made in the role of the health officer, but were far less extensive than envisaged. Abortion services were made more widely available, and the government banned private fees for medically necessary services (which were virtually non-existent in any event). Otherwise, the commitments were quietly dropped.

The second new direction was “greater public participation and responsibility”. It actually contained several new directions: greater public involvement in the health system; greater responsibility of health professionals to the public; and greater responsibility of the public in the use of services made available to them.

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\(^{112}\) MOH (1993a) pp. 9 to 11.
Specific measures the Minister committed the government to included:

- more lay representation on health professions’ governance bodies;
- more public accessibility to hospital and Ministry of Health information for patients;
- access to the Ombudsman’s Office for the pursuit of complaints against hospitals and health professional associations;
- government provision of information to the public on the cost of services provided to them (MOH, 1993a; p.13).

The second new direction, like the first, was a response to Seaton’s recommendations. The government’s record with respect to the commitments was rather better, though. All but the last were the subject of legislative amendments over the first two terms of the NDP government.

The third new direction was “closer to home”. Here the government departed significantly from the Seaton Commission recommendations, although it denied doing so. The Minister proposed Community Health Councils (CHCs) at the local level to “assume responsibility for integration and management of services now delivered by the Ministry of Health, hospitals and provider organizations and resource allocations for the health services in the community. This will provide greater accountability and should reduce duplication . . .” (MOH 1993a; p. 15). CHCs would assume a governance role and local citizens would make the determination of health service priorities. Most if not all services would be amalgamated at the local level.

Regional Health Boards (RHBs) would assume a planning and coordinating function.

*Regional health boards will be composed of representatives from community health councils and individuals appointed by the Minister. . . . Their initial role will be regional health planning and service coordination. This will be expanded in the future to include allocation of a regional global budget . . . In time, funding for medical services will also be a component of the regional global funding envelope* (MOH, 1993a; p. 15).

“The main purpose of creating new governance structures at the two different levels throughout the province was to create greater opportunities for local decision making and local accountability” (BCHA, 1995; p. 2).

The provincial government was well aware that a multi-level governance system would create enormous complexity – especially in the major urban areas which were already organized on a regional basis and where communities, in any meaningful sense, did not

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113 “[The royal commission] recommended the establishment of a decentralized health system in British Columbia” (MOH, 1993a; p. 14). Significantly, this was the only “new direction” the government referred to as a “reform”.
exist. The only plausible explanation for the B.C. government adopting such an unwieldy, and compared with the other provinces in Canada, aberrant model, was their deep commitment to citizen participation. That commitment was rooted in strategic and ideological considerations -- the dyad of interests and ideas.

Strategically, the government sought to destabilize and delegitimize the medical and bureaucratic elites who formed part of the core of the established policy community. Public mobilization and populist rhetoric are familiar tools for softening up the position of entrenched interests. Ideologically, community participation and citizen governing bodies are an inherent part of a “community health position” (Light, 1997). Part of being healthy is taking control over the determinants of one’s own, and one’s community’s, wellbeing. Active citizen engagement is intrinsic to a healthy community.

In addition to the commitment to devolve authority over health services to CHCs and RHBs, the Minister committed her government to reforming the Ministry of Health. She explicitly recognized the reforms would fail without re-organization and “re-focusing” of the bureaucracy (MOH, 1993a; pp. 16-17).

The fourth new direction, “respecting the care giver”, spoke directly to concerns the BCNU had expressed about abuse of nurses by patients and poor working conditions. The Minister committed the government to:

- job security for unionized health care workers;
- a labour relations process grounded in co-management;
- a pay equity plan; and
- strategies to reduce the abuse of health care providers. (MOH, 1993a; p. 17).

As will be shown later, the commitments to labour unions, and the institutions they spawned, were one of the largest legacies of the government’s policy. They also worked systematically to delay and ultimately derail the reform.

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115 Wilkison (1996) for example defines health as a social product generated through social interaction.
The fifth and final new direction was “effective management of the new health system”\textsuperscript{116} The focus of this new direction was accountability. Here the Minister’s position reflected the concerns of the Seaton Commission regarding the power of health care professionals. Amongst the declared directions were taking measures to strengthen the accountability of professional organizations, broadening the mandate of the Professions Council, and developing “alternative payment mechanisms for physicians”\textsuperscript{117} (MOH, 1991a; pp. 18-19).

Effective management was said to also include more rigorous financial and management audits, improved management information systems, and a stronger focus on outcomes. Reflecting themes closer to its labour constituency, the Minister also committed the government to creating a single employers’ association for the purposes of collective bargaining.

\textit{New Directions} ended with a statement that assigned a relatively modest role to the government in the reform process:

\begin{quote}
The government is responsible for leading the way in this reform process, but it is only one participant in a partnership that includes every client, provider, and care giver in the health system, along with other interested citizens (ibid. p. 21).
\end{quote}

\subsection*{4.2.2 A Guide for Developing CHCs and RHBs}

\textit{A Guide for Developing Community Health Councils and Regional Health Boards} was released to communities in May 1993. It described “closer to home” as having “two fronts” – the first was improving the availability and proximity of services; the second was local community control. The two were linked in that the latter, community control, would allow a community to set the priorities for services offered within its locale.

Giving communities the powers to decide which services were most valued by them, and to make provision for their delivery, cut against two possible alternative principles. The first is expert or professional determination of which services ought to be offered (decision making by medical practitioners). The second is determination of which

\textsuperscript{116} The language of “health system” was used throughout the life of New Directions – 1993 to 1996. Health care system only reappeared when New Directions was officially scrapped in November, 1996. The language is not surprising as it emphasized the government’s broader vision of health. Physicians, however, from their perspective, regarded the change in language to be ominous. It literally takes the “care” out of the system, bureaucratizing it and shaping it to meet the state’s needs. See, for example, Silversides (1998) who argued that the use of such language is ideological. A similar position has been argued in this study.

\textsuperscript{117} This was the only reference to physicians in \textit{New Directions}. 

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services ought to be offered by the application of a general rule (decision making by bureaucrats). A Guide opposed both by advocating community democratic processes.\footnote{This once again raises the question of “did the government mean it?” or is the engagement of the community a strategic ploy to gain support against the ministry officials and physicians? The fact that the government continued to pursue the goal of citizen participation and local control in spite of having no supporters and many opponents suggests they were, in fact, serious about their stated commitment to “community health” values, beliefs and norms. As Light pointed out, citizen control at the community level is integral to a community health perspective (Light, 1997).}

The democratic flavour permeates the document. For example, A Guide states:

*A community-based system will provide a democratic planning process for the identification of health priorities, and allocation of available resources in a way that best meets local needs* (MOH, 1993b; p. 2).

A Guide held that CHCs would be “responsible for ensuring considerations of the interests of all segments of the community”. They would be “largely elected . . . to reinforce the accountability of these bodies to the citizens of the communities and regions which they serve” (MOH, 1993b; p. 6). “Democratic public participation must be pre- eminent as new structures and processes for decision making are developed”. All activities at the local level were to be consonant with “the principles of community development” (ibid., p. 9).

A Guide apprised communities that the Minister had formed a new unit in the ministry (detached completely from operational departments) to support community processes intended to heighten awareness and knowledge and bring community members and health care “workers” together in “equal partnership” for planning (MOH, 1993b; p. 7). Processes “must reflect broad community participation and not be dominated by one sector or special interest group”. Communities, “rather than the health community, take the lead” (MOH, 1993b; p. 9).

A Guide recommended that community leaders organize public forums to give local residents the opportunity to debate health services and health priorities. Those leaders were enjoined to be specially diligent in giving opportunities to those “who have been underrepresented in governance and under served by the current system” (ibid., p. 10).

A Guide detailed how the government expected CHCs to assume the governance of health services within their locality and act to ensure integration of services and efficient use of resources. CHCs were also expected to undertake comprehensive health planning and priority setting in consultation with their communities and in collaboration with service providers. Activities and services, under CHC governance, were anticipated to be aligned with community preferences and locally identified health needs. They were also expected to reflect the broader concept of health, both in process (inclusiveness, community development, community mobilization) and outcome (better health, greater responsiveness to community and individual requirements). A Guide also detailed how
CHCs would be formally linked to local government. Local governments from within the community would select one-third of CHC members.

It was evident that *A Guide* envisaged CHCs becoming the major governors and managers of health services.

- *Decision making for the organization, management of health services, and allocation of funding to provider agencies will rest with Community Health Councils.*

- *The functions of the local hospital board will generally be assumed by the Community Health Council.* (ibid., p. 24).

RHBs would serve a coordinating function, ensuring that the independently governed CHCs did not follow courses that negatively affected one another. “The functions of the Regional Hospital District Boards and the Union Boards of Health will be assumed by Regional Health Boards” (ibid.). The reference to Regional Hospital District Boards was presumably to drive home the need for regional approval of major hospital capital projects – the system in place prior to the reform initiative. It also meant the RHBs would be the bodies authorizing local taxation to meet the local authorities’ responsibility of raising 40% of major hospital capital expenditures.

CHCs had dual accountability. “The CHC will be accountable to the community and the Minister of Health” (ibid., p. 5). Their scope of action was broad. Not only would CHCs have discretion over what services were delivered how, but their operating procedures, role and relationship to RHBs might vary in accordance with local needs “and the wishes of local residents” (ibid., p. 4). While the Minister reserved the right to designate some “core” (i.e. mandatory) services, CHCs “will have the latitude to organize the delivery of . . . services . . . in a way that best meets local needs” (ibid., p. 25).

RHBs were to be formed by delegates from each of the CHCs contained in the region. Those delegates would be supplemented, if necessary, by ministerial appointments to ensure “a regional perspective”. “RHBs will be accountable to member communities and to the Minister of Health” (ibid., p. 5).

*[The] role of the RHB will be regional health planning and service coordination. Over time the RHBs will receive and allocate to CHCs a global budget for services delivered by the Ministry and those provided by hospitals and other agencies funded by the Ministry*” (ibid. p. 5).

The model was relatively clear. CHCs would be formed through a community development process and would inherit responsibilities for governing and managing health services within their boundaries. RHBs, comprised largely of CHC members, would ensure that the planning and operation of each CHC’s programmes was coordinated with other CHCs and that each CHC received an equitable portion of the
global funding provided to the region by government. Major capital expenditures in the hospital sub-sector would require RHB approval.

The RHB was constructed to force inter-community consultation and coordination with respect to global resource allocations and hospital construction. The CHCs were constructed to force local government and the health authority to collaborate with each other and the citizens of their community. The design reflects the logic of partnership and collaboration - i.e. the ideas of community health. It also reflects the strategic goal of demolishing barriers.

The existing boundaries of the 21 health units were selected as the basis for the new regional boundaries. "Communities" would be self-defined, but were expected (outside the major urban areas of Greater Vancouver and Victoria) to match up to some degree with local government structures - i.e. Regional Districts. A Guide indicated boundaries were flexible and could be altered by petition to the Minister.

The oddest "direction" from A Guide was the charge to communities to develop their own direction, decide themselves who should be included, come up with their own plan, and make their own recommendations to the Minister on interim CHC membership and boundaries. That process would be assisted by the new Strategic Services Division of the ministry, and facilitated by regional executive directors assigned by the ministry to clusters of regions.119

4.2.3 Our Understanding of Health

The New Directions policy statement was still missing a discussion of health. That gap was closed with the distribution of Our Understanding of Health (MOH, 1993c) in September 1993.

Our Understanding of Health did not propose a definition of health. Instead it provided an account of recent "community health" oriented research. It discussed the importance to health of supportive social networks, employment, income equity, working conditions, education and nurturing environments for infants and young children.

119 "On March 5, 1993, the Deputy Minister released the interim Ministry of Health organization. The new organization notes the six Executive Directors of the Regions, responsible for implementing decentralization and other initiatives of the New Directions document, and the New Directions Implementation Division [Strategic Services] which will function as the ministry's secretariat for the implementation of New Directions" (MOH, 1993i; p. 21).
Our Understanding of Health stated:

... further spending on health services to satisfy the demands of individuals may not improve the health of the population. In fact, increased spending may restrict potential spending in other areas such as housing, job creation, education and early childhood development – the very areas that research indicates contribute most to improving health. (MOH, 1993c; p. 6).

Our Understanding of Health was intended to disseminate a community health perspective amongst the provincial population (ibid., p. 3). It was distributed to households and organizations throughout the province. Strategically, it was hoped Our Understanding would not only inform but also build a constituency of support behind health care reform.

4.2.4 The Health Authorities Act

The fourth and final component of the New Directions’ policy was the Health Authorities Act (MOH, 1993d). Bill 45 passed third reading on July 27, 1993. It established the legal framework for CHCs and RHBs. The Act also bound the Minister of Health to ensure health services in B.C. “continue to be provided on a predominantly not for profit basis” (ibid., section 3(3)). The Minister was also bound to ensure service delivery continued to meet the five principles of medicare as laid down in the federal Canada Health Act.

The provisions of the Health Authorities Act were, by-and-large, consistent with the government’s preceding policy statements. Only two provisions stand out as either not expressed previously or potentially in conflict with the earlier statements. They are:

1. Subsection 9(2) “If an order made or a standard set under this Act by a council conflicts with that of its board, the order or standard of the board prevails” and

2. Section 14, which authorized the Minister to dismiss a board or council and replace it with a public administrator of the Minister’s choosing.

Until the spring of 1995, the ministry interpreted subsection 9(2) to mean that resolution of impasses over global funding or hospital capital construction would be resolved by the RHB. However, the provision was later invoked to mean CHCs are subordinate bodies of, and report to the ministry through, RHBs.

The provision to dismiss a board and replace it with a public administrator was an important new element. Klein (1993) argued that accountability requires the capacity to hold the party who owes it to account. Holding to account requires, in principle, the prospect of sanctions by those to whom accountability is owed. The provision to dismiss
and replace parallels a provision that existed previously for hospital boards. But this approach to board accountability is difficult to reconcile with the community accountability that lies at the heart of a community health perspective.

4.3 Policy Implementation

4.3.1 Communities Putting New Directions into Action

As soon as the handoff was made to the Ministry of Health to implement New Directions, there appeared to be a shift in goals. The first ministry document, Communities Putting New Directions into Action (MOH, 1993f), listed “the four essential elements of New Directions [as] equal access, effective management and planning, efficient use of limited resources, and increasing accountability” (ibid., p. 3). Those four elements do not match New Directions’ four principles (equity, partnership, fiscal responsibility and sensitive implementation) nor the five directions (better health, greater public participation, bringing health closer to home, respecting the care giver and effective management). They have no obvious connection to the vision of healthy citizens residing in healthy communities.

The ministry report went on to say “many British Columbians expressed to the Royal Commission their concern over the cost of health care” (MOH 1993f; p. 3). That did not correspond with what the Commission actually reported – the main public concern was access to care. The document was, in short, shifting the focus from a policy orientation based on community direction toward the bureaucratic preoccupation with cost-control.

Communities Putting New Directions into Action included vignettes of activities in a number of regions preparing for the devolution of health services’ governance. They were constructed from comments made by participants in the planning process. The list of those participants was provided as an appendix to the report. That list identified (out of a total of 26) two physicians, thirteen hospital administrators, hospital trustees and health care managers, six mayors or councillors, one municipal planner employed by local government, and one health care consultant (MOH, 1993f; p. 34). Only three participants appeared to be private citizens. This was not an auspicious start for a broad-based community development process.
4.3.2 Forming Community Health Councils and Regional Health Boards

The document *Forming Community Health Councils and Regional Health Boards* (MOH, 1993g) was released by the Strategic Services Division of the Ministry of Health in the autumn, 1993. Consistent with *New Directions*, it emphasized community control over local health services.

The document explained that local government would nominate one-third of interim CHC members, the local steering committee would select one-third through whatever procedures they adopt, and the Minister would appoint one-third. The ministerial appointees would be chosen from people who were self-nominated in response to public advertisements, nominated by others such as the steering committee, or otherwise came to the attention of the Minister (in practice, by recommendation of NDP MLAs). In 1996, elections would be held to select the community representatives.

RHBs would be comprised of members chosen from within each CHC by that CHC. The Minister reserved the right to appoint additional RHB members, but that right was limited to no more than one-third of the total. The Minister's appointees were to provide "a regional perspective" or ensure the presence of "traditionally under-represented groups".

Left unanswered were questions such as how the different sizes of communities and CHCs would be factored into RHB membership and what criteria the Minister would use to choose her appointees. The process was beginning to move ahead in the communities, but the government had yet to sort out the ground rules.

While several communities were critical of the lack of direction from the ministry, the Deputy Minister and the Assistant Deputy Minister, Strategic Directions, held the view that the process must be kept open and consultative in order to comply with the philosophy of *New Directions*. Communities needed to be given the opportunity to determine what structures and processes best met their needs. Diversity was valued for its contribution to innovation and the breakdown of barriers.

Again, there was the familiar amalgam of ideas and power. Diversity and community control are core values in a community health perspective. They were also instruments deployed to break up traditional arrangements and call into question established ways of thinking about and doing things in the health sector. In part, the Deputy and Assistant Deputy Ministers were working to keep the bureaucracy off balance, preventing it from capturing and controlling the reform.

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120 This comes through clearly in the minutes of the early meetings of the Deputy Minister's Advisory Committee (MOH, 1993 1).

121 The need to work through alternative channels in order to prevent "capture" was explicitly raised by informants. That need was scarcely surprising given the close links between ministry departments and their clients.
4.3.3 Planning for Core Services and Standards

Planning for Core Services and Standards in British Columbia: An Interim Document (MOH, 1993h) was released by the Ministry of Health in November, 1993. The document identified service categories that would be mandated for all regions while retaining enough flexibility "to respond to differing priorities for health services among regions and communities" (MOH, 1993h; p. 1). The approach was permissive. The ministry “determines the general categories of core services and the Boards and Councils determine the type and level of specific services” (ibid.; p. 4).

Planning for Core Services stated the government’s intention to factor off both the Medical Services Plan and Pharmacare from the regionalization initiative (ibid.; p. 6). This contrasts with the Minister’s New Directions announcement; it envisaged eventual RHB control over payments to physicians. Tertiary care services including B.C. Children’s Hospital and the B.C. Cancer Control Agency would continue to be managed centrally (ibid.; p. 4). In short, the ministry had decided between February and November 1993 that neither primary nor tertiary care would be devolved to CHCs.

Planning for Core Services divided core services into “community health” and “personal health”. However, “community health” services were described in conventional terms. The specific services referenced were the traditional public health ones of health inspections, immunizations and the like (ibid.; pp. 10-11). Personal health was comprised of treatment and care. In short, the core services boiled down to the ones the Ministry of Health and its contracted agencies were already delivering – the conventional array of health care services.

Communities and regions, however, were promised the latitude to pursue a broader conception of health and health services. The core services were to constitute a minimum, and even within that minimum, the actual configuration, priorities and amounts of service were discretionary. The government’s position remained a devolutionary one. Communities must have enough scope of action and enough authority to effect real change.

By year end, December 1993, the government had laid the foundations for a single organization to represent employers of unionized health care workers, had established a Labour Adjustment Board comprised of unions and employers,122 and had created a Governance Working Group123 (MOH, 1993i). The government was also involved in a flurry of consultation, and a plethora of working groups and advisory bodies. Several province-wide and regional health conferences promoting New Directions had also been held. Meanwhile, local steering committees had been struck in most communities

122 The unions were the B.C. Nurses’ Union (BCNU), the Health Services Association (H.S.A.), and the Health Employees Union (HEU). The employers were the Health Labour Relations Association (HLRA) and the Continuing Care Employee Relations Association (CCERA).
123 It was comprised of the Ministry of Municipal Affairs, the Union of B.C. Municipalities, the Ministry of Education, School Board Trustees, and the Cabinet Planning Secretariat.
(typically around a core comprised of municipal councillors, hospital administrators and ministry managers). The Executive Directors assigned by the ministry to the regions were active organizing the community-based consultations and work on community health plans.

4.3.4 Regional Health Boundaries; Community Health Council Boundaries

On February 25, 1994 the ministry issued directives on RHB and CHC boundaries (MOH, 1994a). The first directive, regarding RHBs, was of note since it referred, for the first time, to RHBs “operating some tertiary and regional services”. The second directive, regarding CHCs, reflected a subtle shift in language to align it with the first. CHCs would allocate “resources for most health services in the community” (ibid., emphasis added).

There were four reasons for the emergence of “regional services” delivered directly by RHBs. The first was lobbying from the ministry’s own public health and continuing care managers who wanted to keep intact the regional organizational structure of their services. The second factor was lobbying by the “peer group two” hospital boards (supported by the B.C. Health Association) for status as “regional referral centres”. The third factor was increasing concern among Ministry of Health officials over their ability to manage the costs of the hospital sub-sector if hospitals remained (as they had been under the pre-reform arrangements) community governed. The fourth factor was the realization that only regional bodies could coordinate hospital activity in the metropolitan areas of Vancouver and Victoria.

The boundary directives re-affirmed the RHB boundaries to be the old public health district ones. They added the old public health “local health areas” (LHAs) as the natural boundaries for CHCs – presumably in response to municipalities seeking greater direction and lobbying from public health and continuing care employees (MOH, 1994a). Where either the population was too small or historic servicing arrangements were such that the boundaries would be problematic, the Minister expressed preparedness to consider boundary changes upon petition from steering committees (ibid.).

The boundary directives ossified the old Ministry of Health programme boundaries. The directives also opened the door to further lobbying from larger hospitals and Ministry of Health managers for regional governance of health care services.

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124 See, for example, the position taken by the Okanagan Similkameen public health unit (Moorehead, 1995).

125 Regional arrangements already existed in Greater Vancouver and Victoria. It was becoming more obvious to government that there was no sensible way to turn tertiary care facilities responsible for the specialized care of all British Columbians over to local community councils.
4.3.5 Better Provincial Health

The policy statement *New Directions* committed the provincial government to a three-pronged strategy to profile health issues and the new vision of health. The first was to expand the role and the authority of the Provincial Health Officer. The second was to create an independent Provincial Health Council that reported directly to the legislature. The third was to develop provincial health goals (MOH, 1993a).

With regard to the first, the expanded role and independence of the health officer, the government did offer a broader scope of action and a greater degree of autonomy to the new provincial health officer, Dr. John Millar. However, the government drew back from creating an office analogous to the U.S. Surgeon General. The Cabinet of the B.C. provincial government apparently decided ministerial responsibility trumped health advocacy.\(^{126}\)

That position was even more evident in the case of the Provincial Health Council. The government first, in 1993, deferred implementation. Then, in 1994, Cabinet decided to reverse the position announced in *New Directions*. No explanation was offered. Presumably, the government had grown nervous of the prospect of an independent body dealing directly with the Legislative Assembly rather than through the Minister and Cabinet. Further, a body whose mandate extended to all governmental activities, not just those of the Ministry of Health, alarmed other Ministers and their officials. The decision to axe the Provincial Health Council was not well received by health reform advocates. Some questioned the government’s commitment to the reform.\(^{127}\)

The health goals process and its outcomes have been exhaustively researched and reported upon.\(^{128}\) The process itself showed “conditioning” of the goals by the ministry through pre-establishing the themes and orchestrating the consultation sessions. In the end, the goals lacked specificity and their expression was marred by ambiguity regarding what the government meant by the “health system” (Chomik, 1998).

In sum, the government’s performance to the end of 1994 on the promotion of better health was not very impressive. Aside from a broader advocacy role for the health officer, nothing much was achieved. The important factor that inhibited government’s progress was political. Foremost was concern over potential loss of government control.

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\(^{126}\) It is illogical, in a parliamentary system, to have an official report to the legislature independently of the Minister who is held accountable for the programmes and policies of his/her department. There are a few exceptions, notably auditor generals and ombudsmen, who report not on departments or programmes, but how well the bureaucracy is serving the public. The American system, with its separation of powers, is very different. It is difficult to conceive of a Surgeon General in a parliamentary system, just as it is to conceive of Ministers in a congressional one.

\(^{127}\) See *supra*, pp. 110-113.

\(^{128}\) See Treena Chomik’s case study of health goals development in British Columbia (Chomik, 1998).
4.3.6 Towards a New Policy Community

The government attempted three simultaneous initiatives: (1) forging collaborative arrangements with the BCMA, (2) building new institutions to manage labour relations, and (3) constructing a new policy community. The last, forging a grouping of actors actively contributing to, and sharing at least some beliefs and values about, health policy was perhaps the most ambitious, although each was a critical element in the implementation of New Directions.

Government's goal was to create a countervailing power to the medical profession. Activity comprised:

- local community mobilization spearheaded by the ministry appointed Executive Directors;
- bi-lateral negotiations between the Ministry Office of Health Promotion and the Union of BC Municipalities over partnerships regarding healthy communities;
- consultations with health care advocacy and disability organizations;
- creation of the Deputy Minister’s Advisory Committee (DMAC) to pull the other elements together.129

As an institution, the DMAC was not a success. The level of participation fell off over its short (two year) life span. The tone of meetings grew increasingly acrimonious as the position of the ministry diverged more sharply from the positions of the reform advocates and special interest groups representing health service recipients. On the one hand, the attention of organized labour and the medical profession moved from consultation through the DMAC to direct interaction with government through the new institutions formed around labour relations and medicare. On the other hand, both organized labour and medicine showed progressively less interest in the DMAC as the reformist content of New Directions diminished. Consequently, organized labour refocused on issues of jobs and wages, and medicine refocused on the level of public funding for hospitals and medical services.

After a hiatus of nearly two years, the BCMA escalated its campaign over health care funding. As a result of media and opposition party attention, by March 1995 the hospital wait list issue dwarfed regionalization. The alleged funding crisis stayed on top of the health policy agenda from then forward.

129 In all these interventions the government stressed the ideology of community health. It blanketed participants with pamphlets, brochures and reports. Advertisements and information pieces were provided to the media. A web-site was established. Newsletters and fact sheets were published and given wide distribution. Study groups were formed at the local and the provincial level. The newly appointed Provincial Health Officer toured the province meeting with various organizations and the New Directions' steering committees. In short, the government took a "hard sell" approach to its vision of health.
Government’s willingness to consult, and the number of issues over which meaningful consultation could occur, declined between 1993 and 1995. No policy community formed, in spite of government’s efforts to incubate it. Rather than a policy community, or even a loose coalition, key actors fractured into two solitudes – labour relations and medicare. Each now had its separate institutions, frames of reference and actors. Meanwhile, the ministry’s bureaucrats and hospital sector managers increasingly controlled the implementation of regionalization.

The DMAC disintegrated partly due to the diminished scope for meaningful consultation. The government’s rejection of the few concrete recommendations the DMAC made over its life also contributed to its demise. The few remaining participants at the DMAC’s wind-up expressed disillusionment and betrayal over how far policy had wandered from population and community health – indeed any concern over health. Thinking about health services had looped around to centre once again on conventional means of managing health care services expenditures.

4.3.7 The Deputy Minister’s Advisory Committee

The DMAC’s terms of reference were:

- to provide a forum for key “stakeholders”
- to identify opportunities for collaborative efforts and partnerships
- “to provide a forum in which traditional stakeholders in the health care system can hear the views and perspectives of groups outside the traditional health care field but who have a major concern and interest in . . . New Directions” (MOH, 1993, j).

Members were drawn from health advocacy coalitions, the provincial public health association, disability advocacy groups, labour unions, aboriginal organizations, post-secondary education, local government, and the RNABC and BCMA. The University Teaching Hospitals (COUTH) and the BCHA each also had one member.

The positions formally adopted by the DMAC appeared, on balance, highly supportive of ‘New Directions’ philosophy. The DMAC:

- supported a “grass roots”, community development model that would see all CHCs within a region formed before the RHB. (The DMAC opposed “interim RHBs”);

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130 Each professional organization had one representative on the DMAC. The DMAC had a total (initial) membership of 32.
• recommended 100% of all funding for publicly supported health care services come from the provincial government. (The DMAC opposed retaining the 60/40 provincial/local taxation split for hospital capital construction);

• recommended a mixed model of elected and appointed council and board members. (The DMAC opposed elections only because that could preclude participation by minorities and people specially affected by the operation of the health system. The DMAC opposed appointment because it was undemocratic and failed to provide satisfactory accountability to the community);

• recommended dropping the conflict of interest policy, thereby permitting health care providers, including physicians, to serve on councils and boards\(^{131}\) (MOH, 1993 k; MOH, 1993 l).

Ultimately, that is by 1995, the government adopted, in every case but one, contrary positions. The community development approach to CHC formation was scrapped and interim RHBs were formed. The old 60/40 tax split was resurrected. Elections of CHCs were deferred. Only the conflict of interest guidelines were softened, and those not until 1996 (the year following the demise of the DMAC). Further, in spite of spirited lobbying from the DMAC on behalf of the proposed Provincial Health Council the government refused to reconsider the matter.

There was no evidence that the BCMA or BCHA members of the DMAC were converted to the New Directions philosophy through exposure in DMAC meetings. The evidence suggests the members of DMAC talked past one another – health promotion advocates spoke from their perspective, physicians from theirs, and unions and health care lobbyists from their constituencies’ perspectives. Each camp spoke to the ministry’s officials, not to one another (MOH 1993 l; 1994 a, b, c, d, e and f; 1995a and b).

No coalition or policy community gelled – no coalition because there was no common interest shared by the parties and no policy community because the parties held different, irreconcilable perspectives.\(^{132}\) While there was a spirit of cooperation in the early meetings, there was not much else. By the end of 1994, even the spirit of cooperation was gone. Members were criticizing ministry officials for betraying the spirit of New Directions and for cynically manipulating them to suit the ministry’s own purposes.\(^{133}\)

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\(^{131}\) This recommendation is less consonant with the aims of New Directions, but is scarcely surprising given the large number of organized labour representatives on DMAC.

\(^{132}\) Unions and health professionals agreed on the key points that more money should flow into the system, access to services should be expanded, and the relevant health services were health care services. However they disagreed over whose money should flow into the system (private versus public funding), and, perhaps most importantly, the legitimate degree of government control. Interestingly, prior to New Directions the HEU and the BCMA had close working relationships. Their breakdown is another symptom of policy controversy.

Even the minutes of the DMAC meetings were impugned as self-serving and unrepresentative of the parties' positions (1995 b; p. 1).¹³⁴

After the spring of 1994, numbers attending the DMAC meetings steadily declined. Union and local government representatives fell into a pattern of arriving late, leaving early or not showing up at all. Even the Deputy Minister stopped attending on a regular basis. Responsibility was first handed off to the Assistant Deputy Minister, Strategic Directions, then to the Assistant Deputy Minister, Regional Programs. By mid-point (summer 1994) only about one-half of the members were attending; by the end (summer 1995), only about one-third.

There were four reasons for the collapse of the DMAC. The first was that the unions saw little need to do other than keep tabs on the committee after the Dorsey Commission was struck to shape the new labour relations landscape. The second was that the “traditional stakeholders” - doctors and hospitals – were marginalized.¹³⁵ The third was each member represented a constituency and insisted on acting as a lobbyist for it. The fourth was the ministry appeared either unwilling or incapable of acting upon the advice it received. The ministry wanted consensus and “buy-in”, not criticism and suggestions for fresh approaches. The fifth, flowing from the others, was the patent lack of success in pulling together a common understanding of the principles that ought to inform the health care reform.

¹³⁴ That prompted the Assistant Deputy Minister, Regional Programs, to remark: “I feel there is a certain sense of malaise” (1995 b; p. 1). Later in the same meeting she recommended winding-down the committee.

¹³⁵ Health care reform advocates regarded even the presence of physicians and hospital representatives at the Advisory Committee sessions to be incongruous.
CHAPTER V: The Established Policy Frames

5.1 The Ideology of Health Care: The Medical Profession’s Frame

The document *Regionalization of Health Services in British Columbia* (BCMA, 1994) was a comprehensive statement of the medical perspective on B.C. health reform. It summed up the points the BCMA had been making provincially and, through its member Medical Societies, locally, from the beginning of *New Directions*.

The position paper opened with a challenge to the new definition of health. Such a broad definition, the BCMA alleged, was simply irrelevant to a publicly funded health care system (*ibid.*; p. 3).

The BCMA argued that medicare was “introduced in Canada in 1967 to ensure that no Canadian suffered undue financial hardship from either a hospital stay or a required physician service” (*ibid.*; pp. 3-4). The 1984 *Canada Health Act* guaranteed full public payment for physicians’ and hospitals’ services. It did not include any provisions for other health-related services, nor did it extend to social or economic determinants of health (*ibid.*; p. 4).

The BCMA’s position implicitly assumed the goal of the health system was the provision of care to sick, injured or disabled persons. The Canadian system addressing that goal was informed by the principle of individual rights to services, a principle that was institutionally enshrined in the legislation the BCMA referred to. The image of the individual, in this view, is as “a private person exercising their own choices” — a view Light correctly ascribed to a medical worldview (Light, 1997; p. 110; *infra*, p. 54). The exercise of choice entails rights to determine which medical practitioner will be consulted, when, regarding what. It supposes a personal relationship, partially agency and partially fiduciary.

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137 While accurate and uncontentious, the line of argument failed to connect with the government’s project of reforming rather than supporting the traditional health care system. However, the government was more vulnerable to the BCMA’s approach than it ought to have been. By claiming to be subscribing to the principles of medicare, and failing to show how those could be made consistent with the community health perspective, the government left itself open to the BCMA charge of talking (self-serving) nonsense. The government, on their side, seemed to believe the tension between a commitment to medicare and a commitment to community health could be resolved through treating a basic minimum of health care services as one determinant of health. However, it is not simple to “fold in” medicare when its basic principles enshrine individual patient choice among comprehensive and accessible medical and hospital services. Appeal to those principles made much more sense from the health care perspective adhered to by the physicians than from the community health perspective advanced by government.

138 “Fundamental to our quality health care system is the practitioner’s ability to act as a patient advocate. Implicit within this belief is the concept of patient/provider choice” (BCMA, 1994; p. 6).
It is from this perspective that the BCMA asserted:

_This definition [a broader, population-oriented definition] must be refocused to ensure a sustainable, publicly funded health care system in BC_ (ibid.; p. 4).

In other words, the BCMA was describing a system based on the delivery of health care services to individuals.

The BCMA position paper went on to attack _New Directions’_ approach to core services. Those core services, according to the BCMA, were defined too broadly. They provided local authorities with far too much discretion.¹³⁹ Further,

_The government’s approach to defining core services blurs the distinction between core “medical” services and core “health” services. A proper core medical services definition should specifically prioritize medical services on the basis of the known course of disease and the benefits of intervention_ (BCMA, 1994; p. 5).

There are several important points to be drawn from the BCMA’s discussion of core services. First, the attempt to restrain the scope of devolution suggests that the BCMA was sensitive to the issues of power bound up in _New Directions_. Providing authority to communities to prioritize and integrate services threatens to blur borders “on which professionalism relies” (Light, 1997; p. 125). Second, shifting the ground to “core medical services” means that expert (i.e. medical) opinion is required (knowledge of natural history of disease, available treatments and their effectiveness) to set priorities. Third, the requirement that power be aligned with expertise is not merely a strategic maneuver. It is actually derived from the logic of the health care perspective.

The BCMA recognized that their position drove the conclusion that health care professionals, and only health care professionals, had the expertise to prioritize health care services. The BCMA also recognized that _New Directions_ drove the conclusion that only broad-based consultations and community control over decision-making processes could set legitimate health services priorities. The BCMA decided to tackle the government head-on; it challenged the government to live up to its democratic vision by consulting with the general public rather than with government selected “stakeholders”. According to the BCMA, the public would support a narrow view of health services as health care services, and demand more of them to boot.¹⁴⁰

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¹³⁹ It was precisely this flexibility and discretion that was the hallmark of New Directions. That could scarcely be otherwise for a policy that had as its centrepiece the devolution of power.

¹⁴⁰ The BCMA was probably right. New Zealand’s government encountered the embarrassing circumstance of holding community-based discussions on health only to find most people wanted more conventional medical and hospital services. See Wendy Elgar (1998) for a discussion of democratic health priority setting in New Zealand. See also the 1997 Angus Reid Group study. The study found that the public’s views reflected those of physicians. Sixty-three percent of Canadians believed waiting times for surgery had worsened, up from 53% in 1996 (Angus Reid, 1997).” Also relevant in this regard is “Health Care: residents just want more” (Kelowna Daily Courier, Monday, April 5, 1999; p. A-3).
The BCMA roundly condemned the stakeholder consultations, and demanded a process that would put physicians and other health care professionals at the table with government. According to the BCMA, “[policy] development has consisted of limited consultation with specific groups and, consequently, does not reflect the sentiments of the medical profession nor the general public” (BCMA, 1994; p. 5).

The BCMA appealed to the government to alter the definitions of core services. The BCMA wanted highly specific core services and explicit standards for their delivery. Failure by the government to do so would undermine medicare and lead to service variations across localities “seriously affecting the health care infrastructure” (ibid.).

The BCMA position paper asserted “when a patient develops a medical problem, s/he does not care about population health status. S/he needs a caring, understanding professional . . .” (ibid.; p. 6). Anticipating that the government would encourage CHCs once they were established to create community health centres comprised of a mix of salaried personnel, the BCMA claimed the only suitable professional for primary health care was a general practitioner or family physician of the patient’s own choosing (ibid.; p. 7). According to the BCMA, there was no evidence to suggest that nurses could provide appropriate or more cost-effective primary care. There was no reason to believe physicians were not already functioning as effective health educators and contributors to patient and community wellness (ibid.). Further, any erosion of medical or hospital services in the pursuit of a “wellness orientation” would be foolhardy because “people will continue to become ill and require acute care services” (ibid.; p. 7).

In addition to outlining its overall reaction to New Directions, the BCMA made several concrete recommendations consonant with their perspective on health and health services.

- Planning meetings and consultations should be opened up to doctors and scheduled at times that would facilitate their attendance.

- Regional bodies should have only an advisory function.

A study reported in June 1998 (Macdonald et al., 1998; p. 175) showed that the public, health care providers and administrators held remarkably consistent views. All three ranked “inadequate funding” as the number one reason why access to medically necessary services was deteriorating. From a structural point of view this is not a surprising result. The view of those who dominate the health care system – viz the health professions – is the frame that will be institutionalized in the culture, norms and expectations of that system. Thus, in the absence of a capacity to change the terms of the debate, it is scarcely surprising the public remained more open to the doctors’ propaganda than the government’s. The government appears to have agreed with the BCMA’s assessment because it avoided the broad based consultations and the surveys of public opinion that the BCMA demanded. The government was relying on building a constituency of support for the policy through the stakeholder consultation process and co-optation of local government. Neither yielded the expected results. More significantly, they appealed to the Union of BC Municipalities, the BC Health Association, the opposition Liberal party, and the media. They also appealed directly to the public through placing posters and notices in medical offices throughout the province.
• Regional bodies should not be granted taxation powers.\footnote{At first blush this does not appear consistent with a medical ideology. As Evans (1997) has pointed out, physicians rarely miss an opportunity to open up additional potential sources of funding, because multiple sources of funding reduce the capacity of any one actor (i.e. the state) to control overall expenditures. The reason why that strategy does not manifest itself here is that the BCMA feared the provincial government would “offload” programmes onto cash-starved local authorities. “Regional taxation authority too easily becomes a slippery slope whereby provincially elected officials can divest themselves of responsibility ...” (BCMA, 1994; p. 10).}

• If government insists on regionalization, there should be only one tier of governance (the RHB); CHCs should be abolished.

• The deadlines set by the government are unrealistic.

• Conflict of interest guidelines need to be relaxed to allow physicians and other health care providers to serve on health service governing authorities.

• Governing bodies should be elected “with a minimum number of appointments to meet specific, clearly identified needs” (ibid.; pp. 8–17).

The BCMA’s positions on regionalization and elections are of particular interest. Given that the BCMA concluded that the public’s perspective was closer to “better health care services” than “better health”, it seems odd that the BCMA was staunchly opposed to CHCs – the voice of the citizens in the proposed new governance system.

The reasons adduced in the position paper are ones of organizational effectiveness. Eliminating CHCs would simplify the system, reduce duplication, lessen confusion of roles, and cause less bureaucratization and expense. But the vigor with which the BCMA pursued the objective of CHC elimination raises the question of whether there were deeper motives.

The answer is a complex one. It lies in the creation by government of lay boards to limit the power of health professionals. The central idea is to balance the interests of health professionals with broader interests from the community. The “repressed interests” of the general public are mobilized as counterweights to the “dominant interests” of organized medicine (Alford, 1975).\footnote{“Repressed structural interests are those of the community population ... [and are] repressed or negative structural interests because no social institutions or political mechanisms in the society insure that these interests are served” (Alford, 1975; p. 15).} The vehicle for mobilization is the state-created institution of a lay governing board.\footnote{There are many examples of governments consciously creating community boards to set limits on professional aspirations and give voice to non-professional concerns. For example, the 1974 National Health Planning and Resources Development Act mandated over 200 Health Services Agencies in the United States. The boards were comprised of consumers “broadly representative of the social, economic, linguistic [and] racial ... populations of the area” (Morone, 1990; p. 273). Their creation was “a decisive rejection of the view ... that the doctors and hospitals had the last word on how medical care ought to be organized” (Starr, 1982, p. 402). In Canada, Quebec was a pioneer. Citizens were mobilized to form}
Wherever lay health service governance boards appeared, they were met with professional hostility. Referring to the formation of Health Services Agencies in the United States, the president of the American Medical Association retorted “Passengers who insist on flying the airplane are called hijackers” (cited in Starr, 1982; p. 402). In Quebec, medical specialists refused to cooperate with the new community-based agencies. General practitioners responded by forming private group practices rather than working for, or even in, the community governed health centres (O’Neil, 1992). Likewise, in the U.K. physicians lobbied against the proposed “closer to home” CHCs and in favour of more distant regional structures (Ham, 1992).

As Light (1997) put it, “community boards lend legitimacy to people other than providers to manage health care services”. Since the health care service perspective turns on a belief that priorities ought to be set in accordance with technical expertise, community health governance is simply illegitimate.\footnote{One dimension of legitimacy was the BCMA’s claim that local governance bodies would lack objectivity.}

The BCMA positions on conflict of interest and elections were linked. There was good evidence (known to the Canadian and British Columbian Medical Associations’ policy units) that lay governance bodies that include health professionals will defer to their expertise.\footnote{Older sources include Alford (1975) and Starr (1982). More recent ones include Marone (1990) and O’Neil (1992). See also Abelson, Lomas, Eyles, Birch and Veenstra (1995) whose Ontario study confirmed the hypothesis that the public prefers professional guidance on issues of health policy. Their article appeared in the \textit{Canadian Medical Association Journal}.} The government was also aware of that evidence, hence imposed a conflict of interest policy that excluded from governance bodies virtually everyone who had any direct knowledge of, or was employed in, the health care system.

The BCMA obviously wanted physician representation on RHBs to ensure the medical perspective was represented. That could only happen if the government rescinded its conflict of interest policy, opening up eligibility for physicians to serve on boards. In this regard, the unions (who were agitating for board representation for their members) aided the BCMA. The government could not legitimately allow union representation, where there was an obvious real conflict of interest, and deny physician representation, where it was much less obvious that doctors had any conflict of interest, at least in the conventional sense. However, eligibility to serve, alone, would not suffice. As long as the new health care governors were to be appointed by the Minister, it remained unlikely that anyone sympathetic to the medical perspective would find themselves on the health governance bodies, even if eligible to serve. The public, contrariwise, with its traditional (albeit attenuated) deference to medical expertise, would probably support (at least some) physician candidates in an election.\footnote{The BCMA also claimed, and likely believed, that “the existing system of political appointments to RHBs and other positions of authority and management in the health care system has significantly undermined credibility with both providers and the public” (BCMA, 1996; p. 3). In other words, it opposed the apparent partisanship of boards in principle, not only because of the absence of physician members.}
The request by the BCMA to extend the timetable for implementation reflected a variety of motives. The first was simply delay with a view to allow the self-destruction of the policy initiative by its internal contradictions. The second (especially in light of the associated request for pilot projects to proceed prior to full-blown implementation) was closely associated with the medical conservatism and scientism (first a trial, then general application of a treatment). The third was genuine alarm over the apparent chaos in the health sector that the reforms appeared to be generating. On the issue of deferring implementation, the BCMA publicly aligned itself with the Union of B.C. Municipalities who referred to New Directions as “too few directions” and “too many conflicting directions” (UBCM, 1994a).

A BCMA ally that had much more in common from an ideological point of view than the UBCM was the B.C. Health Association (BCHA). The BCHA, which was a body made up of member hospitals from across the province, took as much issue with the broad definition of core services as did the BCMA. Understandably, the BCHA saw the broad definitions of “health” and “core services” as licenses to the new health authorities to reduce hospital funding in favour of other health-related expenditures. The BCHA therefore lobbied hard to have the definitions narrowed and the range of mandated services widened (BCHA, 1994; p. 1). In short, the BCMA and BCHA publicly supported one another, and widely circulated documents quoting each other, on the need to limit dramatically the potential scope of decision making by the new health governance bodies. The logic of their position was familiar: the new bodies (much like the hospital boards that pre-dated them) should have a limited management role over well-defined, prescribed, health care services, leaving questions regarding the actual provision of care where they belong — i.e. with health care professionals.

148 Gladstone and Goldsmith (1995) concluded that the British Medical Association’s request for health reform pilot projects in the UK was not so much a stalling tactic as a commitment to a worldview and a set of methods typical of organized medicine.

149 The UBCM was particularly inflamed over issues relating to local taxation, boundaries and representation. Those concerns were based on the different population sizes, property assessments and rates across the local governments that found themselves rolled up within RHB boundaries. Ratepayers in Kelowna, for example, did not want to pay a disproportionate share of a capital project in Oliver, more than 100 kilometers away and of no value to Kelowna residents. They did not want a community of a few thousand people to have equal voice to one with over one hundred thousand. They most certainly did not want the mill rate (the proportion of assessed value of a property in thousands of dollars payable as tax) to go up by the same amount in all communities to raise capital for health construction. Property values in the central Okanagan were much higher than elsewhere in the region, hence property owners there would pay a disproportionate amount towards projects undertaken in other communities within the region. Similar problems existed throughout the province. The government refused to do the obvious thing — include capital funding in the global envelope provided to the regions. The result was an intractable problem that alienated local government, providing the BCMA and other opponents of the reform with an important strategic ally. Municipal governments in BC are the nurseries for provincial politics. Many municipal politicians were part of, or aligned with, the opposition Liberal party. Very few local governments were “NDP friendly”. Curiously, municipal governments were even more stridently opposed to New Directions than the opposition Liberals — perhaps because they were unfettered as “governments in waiting”.

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In addition to its positions on health and health care regionalization, the BCMA continued making its claim that the hospital and medical sub-systems were under funded. More controversially, the BCMA was the most strident of the provincial medical associations in Canada on the issue of private funding for health care. Successive BCMA presidents, Dirnfeld, Smith, Avery and Lane, argued for more private financing of health care in general, and the elimination of the rising legislated barriers against a parallel private health care system in particular. If government cannot raise the revenues to support adequately the diffusion of technology and access to services by all potential patients, then, the BCMA argued, those who can afford to pay privately ought to be allowed to do so. Those privately paid fees would constitute fresh revenues that would expand the overall infrastructure and capacity, thereby making services more available in both the publicly funded and privately funded parallel worlds.150

Aside from the fact that very few policy makers or members of the academic policy community believed that the argument was cogent, government and the general public regarded it as self-serving. A poll by the Canadian Medical Association showed that more than 70% of doctors favoured such a parallel system (and seemed to genuinely believe it would improve access for their patients). However, only 40% of the general public shared their doctors’ enthusiasm for re-creating a private medical and hospital marketplace (CMAJ, 1996; p. 1084).

On the issue of financing, there is clear congruence between Light’s health professional ideal type (Light, 1997) and the BCMA. That is, the BCMA151 supported a mix of public and private financing of health care. Their position contrasted sharply with the strong support the unions and community health advocates gave to maintaining a fully public medical and hospital system.152 It, together with union agitation against the medical

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150 The past dean of the University of Toronto medical school expressed this thought in a succinct and unusual way: “decriminalize medical acts between consenting adults and allow patients to purchase more medical care than the government provides” (Aberman, 1998).
151 There was and remained a small vocal opposition to private financing within the medical association, particularly amongst family practitioners.
152 The debate and the positions of the parties had a certain unreality, as is usual with ideological disputes. In Canada in the 1990’s, only about 70% of total health care expenditures were publicly financed. Even in the “fully insured” sub-sectors of hospital and medical services, third parties such as the Workers’ Compensation Board or the Insurance Corporation of British Columbia (provincial automobile accident insurance) bought substantial numbers of services, often on a preferential basis, from health service providers. Some services (e.g. cosmetic surgery, reversal of sterilization, newborn circumcision) were not insured and were provided privately. A few (like the removal of warts) were actually de-insured by the NDP government. Numerous tests and minor procedures were conducted by private medical clinics that charged “tray” and other “supply fees”. The government made a show of legislating the elimination of “tray fees” and “user charges” but charges remained in many areas (e.g. allergy testing; 24-hour blood pressure monitoring). Union agitation brought further threats of government action in 1999 — the refusal to pay out of medicare funds for laboratory tests that could be conducted within public hospitals. This was not so much an elimination of part of the private system, as the elimination of public funding to a private system that would then have to rely on private fees for its continued operation. It boiled down to transferring the work from the non-unionized environment of private pathology laboratories to the closed-shop of hospitals. The government’s effort to transfer “bleeding station” work to the unions was so blatantly inimical to other health care objectives, the government was forced to back down.
perspective, provoked a response from government. Legislation was introduced, as part of *New Directions*, proscribing for-profit medical and hospital services.

5.2 The Union Perspective: Organized Labour’s Frame

The largest and most powerful health care unions in British Columbia, the Health Employees’ Union (HEU) and the B.C. Nurses’ Union (BCNU), have been staunch supporters of a publicly funded, state-operated, universal health care system. Both unions have strenuously opposed private-sector involvement in health care delivery,\(^\text{153}\) and both have engaged in extensive public relations activities designed to link union issues such as staffing levels and workloads to public concerns such as quality of care and access to services. Throughout the health reform process in British Columbia, both HEU and BCNU pressed for a number of policy positions beyond narrow issues of staffing, workloads and remuneration. Foremost amongst them were:

- legislated limitations on private sector, for-profit, activities in the B.C. health sector;
- expansion of community-based services prior to downsizing acute-care services;
- expanded roles for nurses, practical nurses and other staff represented by the unions;
- election of health board members;
- direct union involvement in health care governance;
- breaking down the divide between community services and hospital services;
- reducing the numbers, and remuneration of, managers;
- eliminating CHC’s in more populous areas; eliminating RHBs in less populous ones;
- maintaining a strong, directive role for the provincial government (HEU, 1996; BCNU, 1996).

Organized labour opposed for-profit activities in health care primarily because of historic difficulties in obtaining certification to represent workers in private hospitals, long-term care facilities, old age homes, home support services and diagnostic centres such as pathology and radiology laboratories. While the private care market in B.C. remained small, the perceived shortage of public services (and apparent unwillingness of

\(^{153}\) A typical quote from organized labour comes from the B.C. Federation of Labour’s Health Reform Committee Report of February 5, 1995: “We see no place for profit making services within a publicly administered, universally accessible medicare system. Accordingly, we oppose any expansion of for-profit services.” (cited in Dorsey, 1995a; p. 10).
government to pay for more) created a climate from the late 1980’s onwards conducive to proposals such as for-profit facility-based care, private diagnostic clinics, and user-pay surgical operatories. Throughout the 1990’s, neighbouring Alberta adopted U.S.-style approaches to private radiology and day surgery. The North American Free Trade Agreement, signed at the beginning of the decade, promised entry for American health care insurance and health care delivery corporations into any area of health services ceded by the publicly funded Canadian plans. Already, multi-national corporations were opening private long-term care facilities in British Columbia, several of which (such as Hawthorn Park in Kelowna, B.C.) had been sites of bitter union battles. Unions, given this context, feared erosion of public services and their irreversible replacement by union-unfriendly multi-national for-profit firms. Finally, the process of regionalization itself was opening up more possibilities for private sector providers:

*Over the past year, strategies by health care managers to develop plans for sharing services at a regional level, in a number of areas including food services, materials management and information processing have been predicated on proposals for privatizing all or part of these services. It would appear that left to their own devices health care managers at both the regional and provincial level are vulnerable to promises by the private sector that they can manage what are often referred to as ancillary health care services more effectively and at a lower cost (HEU, 1996; p. 7).*

Unions also opposed the reduction of acute care services prior to the development of replacement community-based ones. This opposition remained even after the signing of the Labour Accord that effectively guaranteed all union members continuing work. The opposition was therefore partly grounded in principle. From the union perspective, hospitals are the central provider of health care services. Legitimate community-based health services are provided in order to reduce dependency on hospital care. Community-based services that prevent avoidable admissions and community-based services that allow discharge of patients who no longer need the unique capabilities of a hospital are both, from this frame, construed as adjuncts to hospital services. Services that prevent admissions (community disease preventive services) and services that allow early discharge (rehabilitation, home care, adult day care, and facility-based long-term care) should all be managed by the hospital. The latter, the hospital, is the “hub”, the former, the community services, are the satellites.

The “hospital as hub” perspective is clearly irreconcilable with *New Directions*, although consonant with much of the Seaton Commission Report. In contrast to *New Directions*, the union position explicitly rejected the view that community services, their providers, and their constituencies were, or should be, countervailing forces to acute institutional

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155 This position is particularly clear in the HEU (1996) submission. (See especially page 3, HEU, 1996).

156 HEU noted this higher degree of consonance between its position and Seaton’s (HEU, 1996; p. 1).
care. Health services amalgamation and integration should be understood as hospital-led processes leading to more efficient delivery of a broader range of health care services.

HEU held that the provincial government was confused about the purposes of health care reform. That confusion was evidenced in *New Directions* describing acute care and community services as rivals. It was also evidenced by *New Directions*’ focus on governance. The proper purpose of health care reform, according to HEU, is not change in power and governance, but rather improvement in the provision of health care services to patients and potential patients (HEU, 1996; p. 3). Nowhere is there a signal in the unions’ positions that the community health perspective might be different from the acute care one, nor that these positions might be irreconcilable.

The unions’ demands for expanded roles for their members flowed naturally from their responsibilities to their members. Both major unions agreed on more scope for those members *vis a vis* doctors, but were otherwise in conflict with each other. For example, BCNU could not support greater scope for licensed practical nurses (LPNs), because that would come at the expense of its registered nurse members, whereas HEU strongly supported the Seaton Commission recommendation that LPNs be granted a larger, more independent (in this case from RNs) role (HEU, 1996, p. 10).

Health care unions, for reasons similar to the BCMA’s, supported the election of health board members. As HEU put it, “all members of the regional health board [should] be elected as part of the civic election process” (HEU, 1996; p. 8). Like the BCMA, the unions linked the issues of conflict of interest, *i.e.* the government’s view that all health care providers were in a conflict of interest and therefore are barred from governance roles, with elections. Only open elections without bars on eligible candidates would yield, in the views of both the unions and the BCMA, a legitimate board. In this regard, the unions went further than BCMA by demanding substantial direct involvement in all aspects of health care governance and management (HEU, 1996; p. 6).

HEU in particular saw the regionalization process throwing up more, rather than fewer, barriers to integration of hospital and community services. This is partly attributable to the perspective of hospital-as-hub described earlier, and the contrast between it and the government’s clear bias against hospital services in favour of community-based ones. But it also had an important labour relations element. From HEU’s perspective, the Dorsey Commission’s recommendation to give HEU jurisdiction over the institutional sector and B.C. Government Employee’s Union jurisdiction over community services fragmented organized labour and institutionalized two separate domains of works.

*Dorsey’s recommendations, which were accepted by government, created a line between the community and the facilities in the "health services and support" leading to two separate bargaining associations in this sector. This line makes it more difficult to establish a continuum of services from acute care to the community at either the regional or local level* (HEU, 1996; p. 3).
The unions, again like the BCMA, decried the increase in managers they associated with regionalization efforts. Both unions and the BCMA took pains to remind the government of its commitment to reduce bureaucracy and administrative costs. Closely associated with that view was the claim, again advanced by unions and the BCMA, that the two levels of governance fostered duplication, waste and confusion. As HEU put it, “to ensure that there is less overlap and better co-ordination of services in urban areas, it makes sense to designate the regional health boards and not the community health councils as the administrative unit of governance of health care services” (HEU, 1996; p. 7). In rural areas, CHCs rather than RHBs might assume the same role (ibid.).

The unions were particularly anxious that government not relinquish control over the health care system. Boards were to be accorded only delegated authorities and those were to be exercised under a regime of well-developed standards, governmental oversight, and “strategic guidance” (HEU, 1996; p. 8). Union consultation should be mandated and regional moves to privatize prohibited. Boards should function under detailed “contracts of compliance” (ibid.).

Referring back to the interpretative/action frames (infra, p. 54), it is evident that all of the elements of the union frame were expressed. The unions pressed for the expansion of the range and scope of publicly funded health care services. They sought to maximize accessibility by the public to health care services provided by their members while expanding the scope of practice of their members. The unions saw themselves and the government as the key players in the health care sector. The overall view was bureaucratic, a single organized system based on facility care. Funding should be entirely public; private sector health care services should be prohibited. Health services reform was, from this perspective, about maximizing health care services provided by unionized employees to members of the public. It most assuredly was not about community health.
CHAPTER VI: Towards Better Teamwork

6.1 The Retreat from New Directions

By the end of 1993, only a few months into the implementation process, New Directions was in difficulty. Local governments were deeply concerned by the creation of community and regional health authorities, and by the displacement of local government from the old Union Boards of Health and Hospital Districts. Particularly troublesome were boundary issues and issues related to local taxation.

Local government participants in the steering committees, accustomed to structured processes, reported back to their municipal councils that New Directions was a muddle. The Union of BC Municipalities (UBCM), the umbrella group representing municipalities, applied increasing pressure on the provincial government for greater clarity and direction. The BC Medical Association and B.C. Health Association (BCHA) \(^{157}\) had philosophical and practical objections to many dimensions of New Directions, and were widely disseminating both. Ministry of Health officials in Victoria and in the regions, as well as hospital administrators, were concerned about what the reforms would mean for them personally and the organizations they worked for. Inevitably, as time wore on, the government's strategic advantage eroded, as did its control over the process.

The new Minister of Health, Paul Ramsey, concluded that the community development process leading to the establishment of CHCs before RHBs needed re-examination (MOH, 1994g; p. 1). He concluded that the process was too slow and the responses from the communities too diverse. Mounting opposition led Ramsey to believe that regionalization would fail entirely if it was not hastened. He announced a new deadline for establishing RHBs – October 01, 1995. Ramsey also threatened to dissolve hospital boards that attempted to obstruct regionalization (ibid.; p. 3).\(^{158}\)

Ramsey's speech of February 28, 1994 made it clear the Minister now expected the Ministry of Health to provide direction to the regionalization process. That direction came in the form of comprehensive instructions issued by the ministry shortly after the Minister's speech (MOH, 1994 k).

\(^{157}\) The BCHA represented the institutional sub-sector, principally acute care hospitals.

\(^{158}\) The ministry had already encountered resistance from Peer Group II hospitals and the BCHA. Further, BCHA lawyers counseled hospital boards that they could not wind up their boards and amalgamate. Only the hospital societies had the authority to do so. The government was well aware that special interest groups such as anti-abortionists partially or wholly controlled many of those societies. They would never consent to public governance of those facilities.
In the briefing session following the Minister’s address, it appeared that the government’s view of the roles of CHCs and RHBs was changing. CHCs were now described as having authority over “major front line” community services. RHBs were to “deliver regional services”. RHBs “will operate tertiary services in the region, and those services which are more effectively delivered on a regional basis” (1994j). In short, RHBs now seemed to have a significant direct service role, especially with respect to hospital services.

The changing roles of RHBs and CHCs became even more evident with the issuance of the Community Health Centres and Regional Health Boards Implementation Kit (MOH, 1994 k). The decision to reverse the temporal order of forming RHBs and CHCs now carried with it the implication of subordination of CHCs to RHBs. It also became evident that the ministry had responded with enthusiasm to the Minister’s demand for more direction. The Kit contained directives, check lists, time lines and the threat of unilateral ministerial action in the case of delays. It also contained unambiguous conflict of interest guidelines proscribing the participation in governance bodies by doctors and health care workers. There was equally unambiguous direction on making early progress on integration and amalgamation of health care services.

By way of follow-up to the Implementation Kit, the Ministry of Health hosted a series of Regional Health Forums, beginning in Penticton on March 30, 1994. In spite of selection of attendees by the ministry and careful orchestration of the sessions by ministry staff, the ministry’s records of the proceedings documented considerable confusion and unhappiness. The ministry was criticized at all venues for poor communications and conflicting direction. “All regions listed the lack of clear, consistent communications as a major issue for New Directions” (MOH, 1994 l, p. 4). Similarly, all regions were now thoroughly confused as to what the ministry’s position was on CHCs and RHBs (ibid. p. 5). Representatives expressed concern that the local taxation issue was still unresolved (ibid. p. 12, 13 and 16). Only 59% of participants reported the sessions exceeded or met expectations. In Vancouver/Richmond/Burnaby (the only region where the question was asked), 8% reported “many issues” were clarified whereas 11% reported “no issues” were clarified by the Minister’s speech, the Implementation Kit and the Regional Forum (ibid. p. 41).

Also in the spring, 1994, the government announced the creation of the “Closer to Home Fund”. The goal stated for the fund harkened back to the Seaton Commission: “to cost effectively create and expand community-based health services that replace services traditionally provided only to hospital inpatients” (MOH, 1994 m, p. 1).

The government was moving away from the ideology of New Directions to a more pragmatic posture with regard to regionalization of health services. To some degree the change could have been expected as policy moved into operational issues. What might not have been anticipated, however, was that the roles of key institutions essential to give concrete form to New Directions -- the CHCs and RHBs -- would alter in ways that were

159 Paradoxically, the poor performance of the ministry led to the conclusion that more direction from it was needed.
inconsistent with the original policy. Those alterations on fundamental issues of institutions, governance and accountability accelerated as Ministry of Health officials gained more control over the process.


In British Columbia, we remain committed to the community development and consultation process. But we have to consider how long this process . . . can continue without a goal in sight. (ibid. p. 2).

Ramsey then went on to reject the UBCM proposal to defer regionalization until pilot projects could be conducted. He assured the UBCM that adequate time would elapse following designation of new health authorities and their subsequent assumption of substantive authority. Ramsey further assured the UBCM that the ministry and individual boards would work out all the details before devolution would be allowed to occur (ibid. p. 2).

In response to the UBCM accusation that New Directions was ill-planned, badly led and responsible for considerable confusion, Ramsey wrote that the ministry was now taking leadership (ibid; p. 4). The letter ended with a renewed commitment from the Minister to approach health reform in the most open and consultative way possible (ibid; p. 5).

Ramsey's new position had several effects. Government speeded up the formation of RHBs, but slowed down the actual devolution of authority. The former, quick starts for RHBs, short-circuited the community development process. The latter, delaying devolution, gave Ministry of Health officials, hospital managers, and the BCMA time to consolidate their respective positions.

Evidence of a further shift away from New Directions and toward a conventional health care management approach appeared in July 1994 with the issuance of a substantially revised Core Services Report (1994 o). The approach was remarkably different from that taken in the 1993 document on core services. In fact, the approach mirrored that recommended by the BCMA and the BCHA.

The most significant point of difference between the 1993 version of core services and the 1994 one was the latitude given to RHBs and CHCs to determine service types and levels. That latitude diminished considerably. Core services were now tightly defined, specifically enumerated, and most importantly, qualified by the addition of "required components". Instead of CHCs determining how broad goals could be best met in their locality, the ministry now mandated specific service types and levels. Those service types and levels turned out to be the services the Ministry of Health and its funded contractors were already providing. "These are the services the ministry, over time, has

160 The BCMA made exactly the same proposal.
found important to provide or fund, and that represent public priorities for health” (1994 o; p. 7). The new position was difficult to square with *New Directions*’ view that communities needed, through a public consultation process, to discover what those priorities were.

The 1994 *Core Services Report* introduced other new elements. For example, “core services have also been designed to support and preserve existing cooperative arrangements for services between ministries and agencies”. That statement suggests, and the minutes of the DMAC confirm, that other ministries were reacting to “Ministry of Health imperialism”.\(^{161}\) Other departments had no intention of having their programmes and services shaped by the health reform process. That necessarily reduced the scope of the reform project, narrowed the operative definitions of “health” and “health services”, and restored the centrality of “health care services”.

The 1994 *Core Services* document demonstrated some degree of continuing commitment to local decision making, but local flexibility was now reserved for a single purpose: “to achieve administrative efficiencies in service delivery” (1994 o; p. 3). Gone entirely was the notion of local control over health services priorities, choice of delivery pattern, and re-deploying saved resources into a broader-based health initiative.

*Core Services* reinforced the point that had been emerging for some time: “the Ministry will be responsible for ensuring accountability in the new health system” (1994 o; p. 5). In August 1994 the government confirmed that the Provincial Health Council idea would not be revived (MOH, 1994 p; p. 11). An element that was arguably the very heart of a community health approach -- the framework for income and health -- was also dropped.\(^{162}\) Income would henceforth be treated as one of the factors to be considered in

\(^{161}\) The expression “Ministry of Health imperialism” was coined by the then Deputy Minister, Lawrie McLaughlin.

\(^{162}\) The framework on income and health was one of the priority actions announced by the government as part of *New Directions*. The significance of its demise lay in the conceptual shift it implied. The team working on the framework recognized that socio-economic status is not a personal attribute in the way that physical characteristics (e.g. gender) and behaviour (e.g. eating habits) are. That is, income is not a “personal factor”, but a marker of social position. Rather than recognizing that there were population (class) characteristics such as income and personal ones such as gender, the committee working on the framework opted for apparent consistency and reduced the former into modifiers of the latter. For example, dropping the independent analysis of income and health meant that women with limited financial resources would be regarded as females with additional potential health issues compared to women with greater financial resources rather than part of the class of poor people. Given this reformulation, financial circumstances may matter, but the dominant health variable is gender. The shift has the effect of abandoning a population perspective through converting the analysis to the conventional study of personal attributes, lifestyle, behaviour and environment – essentially Lalonde’s health framework from the 1970’s (Lalonde Report, 1974). In other words, the B.C. provincial health framework moved, by mid-1994, away from a more radical position toward a conventional health factor analysis.

Conceptually, a personal health factor analysis is not consistent with a contextual or structural approach which focuses on the circumstances of sub-populations defined by their position *vis a vis* other sub-populations. That structural approach requires analysis of the social positions people with different health statuses occupy. The objects of study are roles within institutions, power and status consequent to those roles, and the resources available to sub-populations at each level within the hierarchy. Individual
the development of other frameworks for improving health, such as the women's health framework (ibid.).

In September 1994, the Ministry of Health provided interim community and regional health authorities with regulations, by-laws, policies and contract directives. The approach was becoming structured and “top-down” (1994 q).

attributes such as lifestyle and personal environment are strictly secondary. This latter approach is the hallmark of a community health perspective. It is what is meant by the aphorism: “Health is a social product” (op.cit., Wilkinson, 1996, preface).

A conventional factor model is consistent with the medical model and medico-scientific view on the causes of ill health, but not with a community health perspective. An individualistic interpretation of “determinants of health” approach reduces it to personal factors which can readily be incorporated into a medicine and nursing worldview. That is why critics of the determinants of health approach within medicine and nursing typically complain only about “wooliness”, leisurely time lines for results, and the potential to draw resources away from harder clinical services. They typically do not attack the determinants of health approach in principle because it has been implicitly reduced to compatible ideological foundations. See Tesh (1988, pp. 34-82) for a discussion of ideological congruence amongst the “medical model”, “multi-factoral” causal models in medicine, and the health determinants approach. See also Dean (1993) on causality and the medical model.

Unlike a community health perspective, neither the conventional medical model nor the multi-factoral model drives conclusions regarding the fundamental need for changes in power relations and income distribution. The medico-scientific view underlying both is consistent with the inequalities of an under regulated capitalist economy and the power of bureaucracy and experts. The community health perspective, in contrast, calls attention to inequalities of status, income and power.
6.1.1 Executive Directors, Transition Teams and Interim CEOs

Early in the New Directions implementation process, the Ministry of Health took the position that resources for New Directions would have to be found within the ministry's existing budget and staffing complement. The ministry felt compelled to take this public position, if not adhere to the reality of it, because the NDP government was sensitive to the allegation that it was profligate with resources, and New Directions would provide fresh evidence of increased bureaucratization and uncontrolled spending. The BCMA and the Liberal Party opposition were quick off the mark in claiming the RHB/CHC model was a recipe for increased bureaucracy and waste.\(^{163}\)

As a result of the policy of no (visible) new resources for New Directions, the Regional Executive Directors (also known as “Transition Coordinators” and “Regional General Managers”) were drawn from existing ministerial management ranks. They consequently had no community development or organizational development background. Rather they were career health care services managers.

The job of those executive directors was to facilitate the formation of community steering committees (through an open and inclusive process), and liaise between the ministry and local government. They were also expected to support the steering committees once formed in striking the necessary advisory bodies to identify local health issues, set local health goals, and develop the community health plan.

As steering committees gelled, and the work of the planning bodies they spawned proceeded, the need for additional staff resources became apparent.\(^{164}\) While some money was made available by the ministry (out of “slippage” – funds that were committed to other purposes but not spent) for consultants and secretarial support, it was very limited. The main avenue for support was secondment of additional members of staff from the ministry. Staff members were loaned to the steering committees (generally without back filling their regular position, leaving local programmes and services under staffed). Similarly, once interim CHCs and RHBs were set up in a region, they needed interim chief executive officers to complete the community and regional health plans and the detailed governance plans the ministry required. Again, these had to be loaned personnel, from either the ministry or from ministry funded programmes.

\(^{163}\) Close personal links existed between the medical profession and the opposition Liberals, especially at the local level. In the central Okanagan, for example, the Medical Society openly boasted of helping the Liberals to defeat the NDP in the upcoming provincial election. The Liberals, on their side, promised to dismantle New Directions. The Liberal candidate in a key Kelowna riding (Sindi Hawkins) was the spouse of one of the Medical Society activists. She subsequently became the Opposition Health Critic (Shadow Health Minister). In nearby Vernon, the Medical Society candidate, April Saunders, herself a physician and opponent of New Directions, also won a seat for the Liberals in the 1996 provincial election. However, it would be a mistake to assume a coalition formed between the Liberals and the medical profession. See supra, pp. 165.

\(^{164}\) Steering committee members and members of ad hoc advisory committees and working groups were, by and large, unpaid, citizen volunteers. Some were hospital and public health employees, and were therefore partly compensated for their time.
In reality, only Continuing Care and hospitals had managerial cadres large enough to be potential donors. Thus, in practice, interim CEOs were drawn from extended care or acute care – *i.e.* institutional health care services. 165

Aside from the fact that all of the education and formative experience of these managers, and their network of contacts, were within the traditional institutional health care sub-sector, the approach eliminated any meaningful choice by the new health authorities of their executive officer – arguably the most important decision a governance board can make. It also placed many of the new officers in patent conflicts of interest. As they were seconded, and the future of the reforms was far from clear, they obviously would be imprudent to offend their real employer (the hospital) who continued to pay their salary.

Understandably the approach was bitterly attacked by interim CHCs and RHBs. Some feared co-optation by the hospitals (and through them, by the doctors); others saw the displacement of ministry officials into community and regional roles as Victoria colonizing the hinterlands. “There is concern about what is evolving is a mini-Victoria in the regions. Can [sic.] understand protecting jobs, but regions and communities don’t want staff through secondment from the Ministry” (1994 f, p. 14). 166 From a practical point of view, the seconded resources were simply inadequate for the size of the task. 167

The decision by Minister Ramsey in February 1994 to expedite the formation of RHBs brought into being, first informally then formally, “transition teams”. Transition teams were comprised of the ministry managers of programmes such as Alcohol and Drug Services, Mental Health Services, Public Health Services and Continuing Care, plus the administrators, financial managers and personnel managers of local acute care hospitals. They chose their own chair and reported through that chair to the interim CEO of the RHB and the Executive Director from the ministry.

It came as no surprise that the health reform advocates and the unions, except the union representing the public servants involved, objected.

*Transition teams are just Ministry-type people to the exclusion of other groups. Gives [sic.] Ministry staff a strong position at the expense of other groups. They are in place even before [the union-management and health care provider] advisory committees. This is not fair* (MOH; 1995a, p. 18).

165 A survey of 62 CHCs disclosed that, amongst the respondents, 40 out of 49 employed administrators of the local hospital as their CEO (BCNU, 1996; p. 4).

166 The ADM, Regional Services responded to this criticism with “don’t forget there is a working health care system today. I understand the concern of boards, they can be held accountable for what they are responsible for, but the main accountability remains with the Ministry . . . We need to make sure boards understand that the people who are working today are the people who are running the health care system” (1994 f, p. 14).

167 For example, the Central Okanagan CHC, representing 150,000 people and several hundreds of millions of dollars in expenditures was assigned a temporary nurse from Continuing Care to act as its interim executive officer. The Regional District funded the part-time secretary.
A transition team reporting to an interim CEO drawn from amongst the organizations represented on the team created some difficulties. In the Okanagan Similkameen Region, for example, the interim CEO was a vice president of a regional hospital. His immediate superior, the president, was on the transition team. The reporting relationship to the Executive Director was also problematic, since each programme manager on the transition team continued to report to a senior manager in Victoria who was responsible for that transition team member’s programme area. So, for example, the Regional Manager of Mental Health Services under the transition arrangements reported to the Director of Mental Health Services in Victoria, the regional Executive Director (Transition Coordinator), and the RHB interim CEO. Each could, and in fact did, issue conflicting direction on policy, procedure and priorities. Structurally, almost every formal channel now had a backchannel.

An example of the practical implications of forming transition teams and interim CEOs was the split between the transition team and the RHB in the Okanagan Similkameen. Although it was the policy of the RHB (and all of its constituent CHCs) that services would be amalgamated at the CHC level, the transition team prepared papers arguing for a regional approach to public health, continuing care and Kelowna General Hospital. The transition team was supported by the RHB’s CEO, himself an employee of Kelowna General. While the RHB and CHCs held their ground, the ministry ultimately sided with the transition team.

The increasing bureaucratization within regions reflected the drive for improved state control, tighter timelines, and the government’s anger over mounting bad publicity. It also reflected the attempts of local managers to obtain the best position for themselves, their staff and their organizations within the new regions. But it would be a mistake to regard the outcome as a simple function of government’s thrust for control coupled with self-serving or obstructionist behaviour by bureaucrats.

The local managers claimed to be, and acted as though they were, committed to health reform. They agreed with the government’s assessment that services were fragmented and required integration. Their behaviour showed they were open to more public input and a broad governance model for health care services. The interference and conflicting directions from regional executive directors and their line-programme superiors in

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168 See, for example, “Governance Arrangement for Core Service Introduction” prepared by the Medical Officer/Director, S. Okanagan Similkameen Health Unit (Moorehead, 1995).

169 The S. Okanagan Similkameen Health Board passed a resolution at their April 17, 1996 meeting in opposition to the advice of their CEO, the transition team and ministry officials. That resolution reaffirmed the board’s recommendation that Kelowna General Hospital be amalgamated with the Central Okanagan CHC, not the RHB. On April 22, 1996 the board chair, Rod Barrett, wrote to Minister Andrew Petter explaining that the regional and community health plans rested on the assumption of community governance of local hospitals – a condition the RHB and member CHCs felt essential to the effective integration of services at the community level. Mr. Barrett also pointed out that the position of the RHB and CHCs had previously been approved in principle by the ministry. Mr. Barrett concluded his letter with the comment that “[I believe] that an open rift had been created between [the board] and the ministry” and that the ensuing “public battle between Health Directors and the Minister will be damaging to all concerned” (Barrett, 1996). The Minister responded by directing that Kelowna General Hospital be amalgamated with the RHB.
Victoria frustrated them. Officials therefore tried to align themselves with the emerging local authorities and distance themselves from the ministry. They also adopted the language and symbols of New Directions.

While it is no doubt true that the local bureaucrats’ response was partly self-serving, to suggest the behaviour of managers was either merely strategic or quietly obstructionist would be unfair and mistaken. It is not helpful to say their “real motive” or “real interest” lay in control or in maintaining the status quo. The study found that managers had other, equally important reasons for acting the way they did. Those included: loyalty to their staff; commitment to (at least some) existing policies, principles and procedures; attachment to values and goals associated with the philosophies of the programmes they were delivering; and adherence to instrumental beliefs formed around what was found to work in the past. Further, many bureaucrats and hospital officials welcomed regionalization and supported many of the changes it would bring.  

The transformation of New Directions from a policy reform based on principles of community health to a re-organization informed by management principles occurred for reasons that extended far beyond bureaucratic capture of the reform effort at the regional level. Aside from the fact that bureaucratic factors at the local level cannot explain why the government’s stated position changed so dramatically through the policy implementation period (or why the direction of change was consistently towards the conventional welfare state frame), the behaviour of the health managers cannot be reduced to bureaucratic resistance. Officials’ reasons for action were developed in the context of the institutions of the health care system, which in turn embedded the beliefs and goals of traditional medicare and public health policy. In short, the officials held beliefs, values and goals closely associated with the dominant welfare state frame. That, in turn, had implications for their understanding of what New Directions meant and what the government wanted to accomplish.

There are at least three grounds for departure from the philosophy of New Directions bound up in framing issues. The first is that ministry and hospital officials re-framed New Directions, translating it into similar concepts that were actually drawn from a different philosophical position. To take a concrete example, community mobilization may mean empowering citizens to take control over setting priorities and allocating resources (the original vision of New Directions). Alternatively, it may mean providing patients and potential patients with the opportunity to shape some dimension of service delivery, say give expression to their preferences on venue (a position consistent with health care experts determining what is needed).

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170 Importantly, they did not welcome CHCs and lay, elected community governance bodies.
171 As was argued earlier, the two are linked but may not come to the same thing.
172 Re-framing can happen willfully or unknowingly. The latter is more common (Jachtenfuchs, 1996).
173 In the context of U.K. reforms, it has been argued that consumer choice expressed through market mechanisms influenced choice of clinic carpet colours, amenities and hours of operation, but not the clinical services provided (Klein, 1995b; p. 317). In short, aligning service delivery with consumer preferences may be consistent with a medical perspective, whereas public control of medical services definitely is not. An overlap of goals between new public management and community health (e.g.
Systematic translation across frames by actors who have the capacity to influence the shape of new institutions will obviously dramatically change the result. It will do so whether the actors intended, or even understood, the consequences.

The second ground for departure is that the New Directions policy statements were ambiguous. The meaning of “health” and “health services” was unstable. The policy was not very clearly expressed, and its goals were vague. Goals regarding universal, comprehensive medicare potentially conflicted with policy goals associated with community health. Bureaucrats attempting to implement the policy were understandably confused. Confusion over what the goals actually were facilitated goal substitution of more easily secured, more proximate goals (such as community consultation) for more difficult, longer-term goals (community governance).

The third ground for departure is that the government’s description of the goals and the institutions that were to give life to the New Directions philosophy changed in response to the public’s reaction to attacks from the BCMA, UBCM, BCHA and the Liberal Opposition. The vision of the Minister who introduced New Directions, Elizabeth Cull, was not nurtured and refined by her successor, Paul Ramsey, who was burdened by the rising tide of discontent that implementation brought upon the government. As government panicked, it improvised and attempted to re-gain control. That opened the field to the health care managers who had been shut out of the design of, and early attempts to implement, the reform. They were forced to make sense of the ideas and goals and achieve results as best they could. That dynamic favoured the return of familiar patterns of thought and action.

6.1.2 The Waiting List Crisis

By the close of 1994, the BCMA’s and Local Medical Societies’ public-action campaigns developed enough momentum to capture media attention. Anecdotal reports of excessive wait times for cardiac surgery, joint replacement and cancer treatment exploded into a full-scale crisis for the government. By February 1995, regionalization was off the front burner in the Ministry of Health; attention was focused on managing the public perception of a collapse of the acute care sub-sector.

The government fired back with a set of “fact sheets” disputing the claims that waiting lists and waiting times had grown. The ministry claimed both “remained constant over the past 10 years” (MOH, 1995 f). It also claimed utilization was now being managed effectively. According to the ministry, the joint-government-BCMA clinical guideline initiative and the $1.25 million “appropriateness of care” hospital initiative would ensure timely access to truly necessary services (MOH, 1995 f). However, the government felt compelled to inject an additional $6.9 million in one-time money into cardiac surgery decentralization, delayering, public consultation) facilitated re-framing by bureaucrats who confused the former with the latter.
The government also committed to $70 million in new capital for the expansion of cancer treatment (MOH, 1995 h). The ministry also published and widely circulated a brochure entitled "Investing in Health" (MOH, 1995 i). The brochure claimed that British Columbians were the beneficiaries of "an additional $1.2 billion health care investment made over the past four years". The money was allegedly spent on hospitals and allied health facilities, as well as on two new cancer clinics. The brochure also claimed that, over the preceding few months, more than $21 million had been pumped into the system to shorten wait lists. An additional $245 million was promised for treatment centre capital projects.

The 1995/96 government budget announcement highlighted an additional across-the-board increase for hospitals of 3%, a 4.5% increase for community programmes, and an 8% increase for continuing care.174

In spite of government advertising and the infusion of additional money, the issues of waiting lists, waiting times, and the level of funding to hospital and medical services were to dog the government from March 1995 to the end of the period under review. In fact, the crisis deepened considerably in late 1998 and early 1999 as unions and doctors stepped up job actions for more money, and as the BCMA put its "medicare in crisis" campaign into high gear.175

6.1.3 Regionalization of Tertiary Care Services

In March 1995, the Lovelace Report (MOH, 1995 j) was released to a storm of controversy. In light of the experience with denominational hospitals the ministry anticipated that integration of Vancouver area specialized hospitals would diminish the profile and advocacy potential of special interest groups such as lobbyists for the disabled, those with arthritis, women, children and so on. The ministry consequently concluded those groups would resist integration, and therefore instructed Lovelace not to consult with them (MOH, 1995 j; p. ii). That prompted Lovelace to comment "the advocacy role for special health needs and populations may be diminished or lost with the integration of hospital boards" (ibid.; p. 5). Nevertheless, given his terms of reference, Lovelace recommended a regional integration plan to the government, and the government accepted it.

174 The document failed to note that much of the increase had to do with the labour adjustment strategy. In short, it was the transfer of additional income and benefits to health care workers that the Seaton Commission had warned against.

175 See, for example, the BCMA Waiting List Report II (BCMA, 1998). The BCMA enjoyed the support of the right-wing Fraser Institute not only on the issue of growing waiting lists, but also on the BCMA's proposed cure - allowing the development of a parallel private health care system. See the Fraser Institutes' series Waiting your Turn: Hospital Waiting Lists in Canada, especially the 4th through 8th editions - 1994 to 1998 (Ramsey and Walker, 1994 to 1998).
The Arthritis Society, umbrella groups representing spinal cord and head injured people, and other special interest groups accused the government of betrayal (MOH, 1995 b). This was not the community development, consultative model promised by New Directions. The connections between specialized treatment and rehabilitation services, advocacy organizations, and foundations that raised funds for disease and disability-specific groups were seen to be threatened. Angry and alienated, the advocacy organizations abandoned what was left of New Directions. Release of the Lovelace report spelled the end of their participation in the DMAC and contributed significantly to its demise. More broadly, it meant the end of “stakeholder consultations

6.1.4 Roles and Responsibilities of CHCs and RHBs

By March 1995, the Minister had designated all RHBs and approximately 70 CHCs. However, many of them only partially represented the steering committees that preceded them. Some steering committee members tired of the process and withdrew, others sought ministerial appointment and were found wanting. The effect was the new health authorities had to begin the process of orientation and board development afresh. Meanwhile, the ministry transition teams carried on planning the future form of health care delivery in the regions.

Surprisingly, as late as May 1995, the ministry offered flexibility as to how CHCs and RHBs could define their roles and relationships. The ministry offered three models for consideration by CHCs and RHBs. Model I involved regionally integrated support services and devolved (to the communities) programme delivery. Model II involved regional programme delivery with some delegation of services to communities. Model III involved full devolution to communities, with RHBs performing a coordinating role (MOH, 1995 k).

Less surprisingly, the ministry now took the position that CHCs were accountable to RHBs and RHBs were accountable to the ministry. The hierarchical reporting relationship reflected what had already happened with the managerial cadres -- i.e. the fact that the transition teams had been organized at the regional level, and reported at that level to the ministry. The model began to more closely resemble the Seaton Commission Report’s recommendation regarding “regional managers”.

In February 1996, the ministry issued directives to the RHB and CHC members. Boards at both levels were to follow the “Carver Model” of board governance, which called for an expansive role for management under a visionary CEO and a narrow policy role for boards (Carver, 1990). Rather than the ministry’s earlier emphasis on full integration of all services through amalgamation, Building our Future (MOH, 1996 a) suggested scope for the alternative of contractual arrangements and affiliation agreements. There were

176 “Most major non-profit services will be expected to amalgamate with the RHB or CHC; others will affiliate or continue to contract their services” (MOH, 1996 a).
also hints of contractual arrangements between the ministry and RHBs, RHBs and CHCs, between CHCs and between RHBs. In short, a bit of quasi-market flavour had crept into regionalization, along the lines of the service purchaser/service provider split pioneered in the U.K. and New Zealand.\footnote{177}

*Building our Future* also signaled an important change in the role of the CHC representatives on RHBs. They were now instructed to act as regional representatives, not as representatives of their individual communities. That direction was in flat contradiction to the logic of the *New Directions* model wherein CHC representatives sat on RHBs precisely so they could express their communities’ interests (MOH, 1994 i; pp. 2, 3 and 4).

CHCs and RHBs were further enjoined to develop processes for striking Health Care Service Providers’ Advisory Committees (HCSPACs). The HCSPAC was to provide expert advice and information to the health authorities. It would be comprised of nurses, health administrators, other health care professionals, health sector workers and doctors. An amendment to the Health Authorities Act now allowed the chair of HCSPAC to sit on the CHC or RHB, but not hold executive office. In short, the government finally buckled to union and medical pressure for representation on the boards.

6.2 Evaluation of *New Directions*

6.2.1 Ministerial Review and the Assessment Team

In June 1996, Joy MacPhail replaced Paul Ramsey as Minister of Health. Groups affected by regionalization, including her own ministry staff, immediately assailed her. The new health authorities, ministry bureaucrats, the unions, the BCMA and the health coalitions agreed on one thing. They all impressed upon the Minister that *New Directions* had produced very little over the preceding three years except rancor and confusion. In response, MacPhail called an immediate moratorium on health reform.\footnote{178}

MacPhail attempted to establish a review process involving government and opposition members of the legislature. However, the opposition refused to cooperate, and she was left with a review team comprised of two urban and two rural NDP members of the legislative assembly. Three officials, independent of the ministry, were appointed to support the review team.

\footnote{177 The Capital Region (Greater Victoria) actually evolved along these lines. This observation is owed to a discussion with Ken Fyke, the CEO of that RHB and a past-deputy minister of health.}

\footnote{178 By now “New Directions” was considered a curse and the expression was expunged from the ministry discourse.}
Hearings were held from late July to early September, 1996. The Assessment Team met with all 20 RHBs, 80 of the 82 CHCs, the BCMA, the health care unions, and a host of others. It also received more than 380 written submissions (Assessment Team, 1996).

Four key factors surfaced as causing problems for New Directions' implementation. The first was confusion (and disagreement) over the roles of CHCs and RHBs. A number of communities outside of the metropolitan lower mainland continued to pursue integration of services at the community rather than the regional level, despite the ministry's shift in the opposite direction. In the lower mainland it made no sense to speak of community governance of services, because "communities" were only neighbourhoods and services, especially hospital ones, had intricate and extensive interdependencies.

Second, the issue of public participation was contentious. Most interim community health councils had successfully mobilized a significant number of local citizens, and many interim health authorities continued to believe only an active citizenry exercising meaningful control would achieve the goals of New Directions. However, in some regions of the province, members of the public felt that the ministry in collusion with unrepresentative local governance bodies had commandeered the process. They complained to the Assessment Team that the old actors – the local government officials, potentates from the hospital boards, and ministry officials – had re-formed their triangular trading pattern under the cover of the new health authorities (Assessment Team, 1996; p. 12).

That raised the third difficulty, one that was not explicitly discussed in the Assessment Team Report, although clearly implicit in it. Ministry officials not only moulded the reforms into a shape that better matched their interests and perspective on health policy, but also moulded the Assessment Team process and its findings.

The fourth issue was that of amalgamation. The ministry had already hinted that affiliation agreements and contracts might be alternatives to integration and amalgamation. Many boards, particularly of larger institutions, very much wanted to maintain their independence. Considerable pressure had built up against across-the-board amalgamation. The exemption granted to ecclesiastical organizations added fuel to this particular fire.

The major recommendations of the Assessment Team had been foreshadowed by the direction in which the ministry had been moving since February 1994.

- There should be only one level of governance below the Minister of Health in all areas of the province.
- Rural areas should have different arrangements than urban ones.

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179 The Assessment Team met with 45 organizations in total.
180 The issue has been raised explicitly by Jack Altaian, one of the three officials who toured the province with the Assessment Team hearing briefs and providing technical advice to the MLAs.
181 Jack Altaian quipped "You would not believe the number of agencies that found God as a result".
• Physicians and unionized health care providers should be voting members of
governance bodies.

• Members should be appointed, not elected.

• Members should not be remunerated.

• Affiliation arrangements should be extended to smaller facilities and community
  services.

• More emphasis should be placed on developing strategies for reducing unnecessary
  health expenditures.

The Minister accepted all of the recommendations. She announced, based on them,
Better Teamwork, Better Care on November 29, 1996 (MOH, 1996a). New Directions
was officially dead.

6.2.2 Better Teamwork

The Better Teamwork ministerial announcement reduced the Regional Health Boards to
eleven. The remaining seven were dissolved. The 43 CHCs in areas with RHBs were
also dissolved, leaving (after six mergers) 33 CHCs.

CHCs were maintained in areas where geographic distance between communities and
their small size made regional boards problematic – i.e. in rural and remote parts of the
province. In those areas, ministry staff would not be transferred to individual CHCs but
would report to Community Health Services Societies whose boards would be comprised
of CHC members plus a representative of the staff.

Reversing the position taken under New Directions, the government decided Regional
Hospital Districts would remain in place. Regional Health Boards and Community
Health Service Societies would need hospital district approval for capital projects
involving local taxation.

Councils and boards would operate under ministerial delegated authorities. They would
be governed by detailed management contracts. The Minister would have the power to
remove a council or board and replace it with a public administrator. RHBs would have
15 members (18 in Vancouver/Richmond), all appointed by the Minister. In addition to
the 15, the Minister would also have the right to appoint ministry staff to RHBs. Boards

182 Vancouver and Richmond RHBs were merged. Simon Fraser and Burnaby RHBs were also merged.
would now include one physician and one health care union representative as full voting members (MOH, 1996 b; p.4). Under the new policy, all hospitals (except denominational ones and those in Greater Vancouver183) would be expected to amalgamate with the RHB or CHC. Other publicly funded facilities and programmes would be allowed to retain their independent identity but would be required to enter into affiliation agreements with the RHB or CHC. For-profit organizations would only receive public funding through contracts negotiated with the new health authorities (MOH, 1996 b; p. 7).

The *Better Teamwork* announcement package also included news of the government’s intention to transfer Alcohol and Drug Services, child and youth mental health services and community health services for children back to social services under the newly created Ministry for Children and Families. No deadline or mechanism was disclosed; however, it was clear the scope of services to be managed by RHBs and CHCs was now the narrow band of traditional health care services.184

The policy statement that accompanied the Minister’s announcement of *Better Teamwork, Better Care* (MOH, 1996 e) identified a new policy goal. It was “to improve health care for people”. The government’s priorities were now described as “health care priorities” (emphasis added). They included:

- **Ensuring access to the service you need when you need it**
- **Providing the best quality of care**
- **Keeping hospital lengths of stay as long as needed, but as short as possible**
- **Keeping waitlists as short as possible**
- **Encouraging and providing innovative new services**
- **Ensuring patient satisfaction**
- **Ensuring we make the changes needed that will help keep our public health system affordable for the future.** (MOH, 1996 e, emphasis in original)

The media warmly received *Better Teamwork*.185 The province’s largest circulation newspaper, the Vancouver Sun, editorialized: “Joy MacPhail has taken a welcome knife to the numbers of boards and commissions [sic.] which drop to 45 from 102 . . . The overall direction is healthy . . .” *(Vancouver Sun, December 07, 1996)*.

Anti-abortionists were less pleased. The decision to appoint rather than elect board members was regarded as a move to eliminate their influence over hospitals. Ted Gerk of the Pro-Life Society of B.C. claimed there was “no doubt” the decision to eliminate

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183 The “cluster board” arrangement would be retained in Vancouver. Hospitals were grouped through partnerships and affiliation agreements.

184 *Better Teamwork* re-introduced the language of “health care services” after an absence from ministry policy documents of over three years.

185 MacPhail “tossed out the New Directions program the previous New Democratic Party administration had promised would lower costs and return control of health care to local communities . . . Most of those in the system agreed . . . the new scheme is an improvement on New Directions” *(Vancouver Sun, Nov. 30, 1996, p. A.3).*
elected boards was intended to block anti-abortionists. B.C. Campaign for Life Coalition spokesperson John Huf alleged the government would like to see abortion in every hospital (Vancouver Sun, Dec. 02, 1996).

The Registered Nurses Association of B.C. was appalled at the loss of elected boards and councils. “We’re back to Victoria dominating decision making through total control of appointments to regional health boards and community health councils” (ibid.) 186 However, the BCNU applauded the abolition of the two tiers of governance and the decision to appoint rather than elect the governors. Their president called the new policy “a big improvement” (ibid.).

The BCMA and Local Medical Societies opposed the new policy. While pleased that the CHCs were gone, the medical profession held fast on its position regarding elections. In this regard, medical staff lent support to those hospital boards who opposed amalgamation on the grounds that government appointed bodies were replacing democratically elected hospital boards.

Those boards broke down into three classes: boards that supported elections because they were opposed to abortion 187, boards opposed to appointed CHCs because of the perceived loss of local control and citizen participation 188, and the Richmond hospital board that wanted Richmond rather than Vancouver residents governing their hospital.

Senior managers seemed pleased with the change. Ken Fyke, a past Deputy Minister of Health and the new CEO of the Capital Region Health District praised Better Teamwork:

[People] want to make sure they get a service that is quickly accessible and of high quality and get on with their lives. When they need an open heart [operation/ or they need an angioplasty or they need home care nursing . . . what’s important is they receive it in a timely manner. That’s what we need to focus on. The new health care system should allow people in health care to do exactly that (Vancouver Sun, Saturday, Nov. 30, 1996; pp. A3 and A6).

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186 See Bruce (1997) for an analysis of Better Teamwork. Bruce argued that the philosophical foundations of Better Teamwork, unlike New Directions, were incompatible with the philosophy of the RNABC.
187 See Kelowna Capital News (Wednesday, March 05, 1997, A.6) regarding Kelowna General Hospital’s board and the abortion issue.
188 See the Vancouver Sun (Tuesday April 01, 1997 B.5) regarding rural hospitals that took this position.
6.3 Implications for Labour Relations

Integration of services at the community and regional levels, and devolution of authority to councils and boards to manage those services, had profound effects on labour relations. That was recognized early on by the Ministry of Skills, Training and Labour (MSTL).

To start with, it is obvious that the scope of change in the employer identity is vast: of the hundreds of employers in the present health care industry, most of them – including some of the biggest – will cease to exist altogether (although their employees will continue working and providing health services to the public). Moreover it is not simply a case of functional units continuing as before, while the corporate identity of the employer changes. Service integration is a main purpose (if not the main purpose) of restructuring (MSTL, 1995).

Even prior to the health reform, B.C.’s health sector had – through patterned bargaining, master agreements and other labour arrangements – de facto multi-employer bargaining units and multi-employer associations. The “whipsawing” caused by individual union locals (such as an HEU local) bargaining with an individual employer (such as Vancouver General Hospital) forced the provincial government to develop a labour relations model whereby multiple locals of a given union faced multiple employers represented by an employers’ association. From 1975 to 1994, the union represented all hospital locals of that union across the table from the Health Labour Relations Association (HLRA) which represented all public hospital employers. Similarly, the union represented all of the long-term care locals of that union across the table from the Community Care Employees Relations Association (CCERA) which represented all public long-term care employers. The same arrangement existed for unionized workers and employers in private, for-profit, operations. PRICARE (Private Care Employers) represented the employers. In short, twenty health care unions with hundreds of locals negotiated with three employer associations with hundreds of members.

Had those arrangements not already existed, the government would have almost certainly legislated a single union for all health care workers affected by regionalization, as government had, for example with public school teachers. As Dorsey put it, “if the Ministry were starting from fresh with no history, the Ministry would seek one bargaining unit and one trade union representing all employees” (Dorsey, 1995a; p. 7).

However, a government dependent upon labour support moving with less than two years in its mandate and facing institutional arrangements with twenty years of history was not about to attempt legislating the unions out of existence. The alternative would be to allow the Labour Relations Board to make determinations on such questions as union

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189 All teachers in the province were placed by legislation (Public Education Labour Relations Act) into one union. Government did take this legislative approach with respect to the health care employers. Bill 78, the Public Sector Employers Act, created in 1993 the Public Sector Employer’s Council (PSEC) and forced the merger of HLRA, CCERA and PRICARE. However, it did not dare legislate a solution to the union issue.
membership, succession rights and the like. However, neither the unions nor the government was prepared to face the uncertainty and turmoil of union jurisdiction battles fought out before the Board. The government therefore created, by legislation, a third option – a Commission of Inquiry. The idea was to broker a consensus amongst, if not all, at least the most important health care unions (i.e. HEU and BCNU). Thus, in 1994, Bill 48, the Miscellaneous Statute Amendment Act No. 2, established the Health Sector Labour Relations Commissioner.

Jim Dorsey, a labour lawyer, was appointed on January 24, 1995 to advise on how the 20 existing unions and hundreds of separate collective agreements could be reduced to a number that would make regionalization practical. The initial conditions were, to put it mildly, complex.

- Union sizes in 1994 varied from the health sector giants\(^\text{190}\) (HEU with approximately 40,000 members and BCNU with about 30,000) to midgets (PARI representing 300 residents and interns).

- A number of unions had members in a variety of sub-sectors – hospitals, continuing care and community services.

- Some unions had unusual mixes of members ranging from professionals to technicians to manual labourers.

- Union rivalries were intense. Several unions staged unfriendly raids on their comrades.

The government had also made a number of prior commitments. In the spring of 1994, Health Minister Paul Ramsey promised the B.C. Federation of Labour that no devolution to boards and councils would occur until the issues of union representation and employers of record were resolved. In March 1994, the Public Sector Employers’ Council (PSEC) promised the BCNU that successor employers would be required to employ all currently employed nurses, including casuals and auxiliaries (Dorsey, 1995a; p. 7). In September 1994, Ramsey wrote the president of the B.C. Federation of Labour. In that letter, he stated: “I am pleased to reassure unions representing health care workers that their members will be transferred in a manner that ensures their continued representation by their unions and the maintenance of their terms and conditions of employment” (cited in Dorsey, 1995a; p. 8).

Given those initial conditions, no consensus was even faintly probable. Dorsey, unsurprisingly, sided in the end with the largest and most powerful unions\(^\text{191}\), those with clear dominance in a given sub-sector\(^\text{192}\), and those with specialized memberships.\(^\text{193}\)

\(^{190}\) By 1995, HEU had over 120 staff and raised more than $20 million in union dues. Because of designation as an essential service, HEU and other core hospital unions such as BCNU did not have to run much of a strike fund. They therefore had enormous capacity for lobbying.

\(^{191}\) HEU and BCNU.

\(^{192}\) BCGEU and UFCW with 3,000 members each in community services.
Equally unsurprising, when the government accepted Dorsey’s recommendation that only seven unions continue to represent health care workers, the thirteen “out unions” immediately filed a court challenge.

As a result of the Dorsey Commission recommendations (Dorsey, 1995b), five bargaining tables were created for the purpose of melding the hundreds of collective agreements. The bargaining tables, the numbers of workers represented, and the unions involved were:

<table>
<thead>
<tr>
<th>Name of Table</th>
<th>Employees Affected</th>
<th>Unions Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents</td>
<td>500</td>
<td>PAR</td>
</tr>
<tr>
<td>Nurses</td>
<td>26,000</td>
<td>BCNU</td>
</tr>
<tr>
<td>Para-Medical</td>
<td>13,000</td>
<td>H.S.A. and BCGEU</td>
</tr>
<tr>
<td>Facilities</td>
<td>43,000</td>
<td>HEU, IUOE and BCGEU</td>
</tr>
<tr>
<td>Community</td>
<td>14,000</td>
<td>BCGEU, UFCW and HEU</td>
</tr>
</tbody>
</table>

Negotiations began on February 22, 1996. They broke down by April 01, 1996 with more than 150 disputed contract items at an impasse. On April 23, 1996 government faced legal strike action by one or more unions. It appointed an Industrial Inquiry Commissioner – Vince Ready – “to inquire into and make recommendations to the parties” to secure labour relations stability and promote conditions favourable to an early settlement between HEABC and the unions.

The Ready Report (Ready, 1996) was released on May 08, 1996. Ready recommended that each of the five labour relations tables form committees comprised of six union representatives and six employer representatives. Each committee would have a mandate to meld the existing collective agreements into one, but only where melding carried no cost implications. This was referred to as the “melding process”.

Ready also recommended that all superior benefits be identified. Where superior benefits existed under one of the (expired) collective agreements, all the lesser provisions would be “levelled up” to match them. Ready recommended the government set aside $9 million in one-time money to pay for this “levelling up process”.

No provision was made for levelling up contracts at the community table, where wages and benefits were typically lower than in other sub-sectors. Nor did Ready recommend to government the allocation of any funds for that purpose. Further, his report made no recommendations regarding the ongoing cost of wage and benefit increases associated with levelling up.

Ready’s proposed settlement went to the unions and the members of HEABC for ratification. The unions voted over 90% in favour; the employers voted 60% against. HEABC complained that it had been shut out of the Ready Commission process, and the

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192 HSA representing 9,000 non-medical, non-nursing health professionals, PARI representing interns and residents, and IUOE representing boiler engineers.
analysis of costs associated with levelling up had been ignored. The government, in spite of rejection by the employers, ordered the settlement on June 12, 1996 (HEABC, 1996a). An appeal to the Premier for further negotiations prompted the reply: "I cannot see how further process can do anything but introduce unacceptable uncertainty and instability" (HEABC, 1996b).

The government eventually lost the court action launched by the "out unions". They also faced agitation from the HEU and the BCNU to open up the bargaining process. In response, on May 21, 1997, the government introduced new labour legislation, Bill 28, which allowed any union to seek members in the health sector. However, the number of collective agreements would remain at five "forcing multiple unions to work together in bargaining associations" (Vancouver Sun, Saturday, May 24, 1997; p A1 and A9).

The new union bargaining associations, with weighted voting, clearly favoured the giants — HEU and BCNU. The BCGEU, a traditional government supporter, was bitterly disappointed. More angry than disappointed, Gary Moser, head of the HEABC, insisted that he had not been consulted, and was opposed to the changes.143

It had become obvious that the creation of PSEC in 1993 had a profound impact on B.C.'s public sector labour relations. PSEC oversaw negotiations between the unions and the new omnibus employer association — HEABC (Health Employers' Association of BC). As unions and government were included in PSEC, both could second-guess the nominal employers. The unions could appeal directly to government, and vice versa, with only marginal involvement by the employers of record. That, in fact, became the pattern of B.C. health sector bargaining after 1993, not only for the unions, but also for the medical profession.

The direct union/government negotiating pattern did not lead to labour relations tranquility. The first major bomb went off under the government in February 1997 when unions claimed the Premier misled them in the lead-up to the 1996 provincial election. According to the union sources (corroborated by the government's chief negotiator), Glen Clark promised a pay-equity settlement immediately prior to the May 1996 election in order to maintain labour peace during the campaign. The money never materialized and BCGEU applied to the Labour Relations Board asking it to declare illegal the June 1996 ratification vote which (according to the unions) was based on Clark's promise. The disputed contract involved 42,000 health care workers. (Vancouver Sun, Monday February 17, 1997; p A1).

The second bomb went off a month later. The BCGEU and HEU attacked the government over lack of progress on "levelling up" in the community care area. According to the HEU, community workers were earning two to seven dollars less per hour than workers in comparable hospital jobs were. Stephen Howard, the communications director for HEU, also claimed that Glen Clark had pledged to HEU members at a meeting in the autumn of 1996 that his government was committed to pay

143 “But MacPhail insisted Moser was 'certainly well briefed on this matter'. 'I must have missed it,' said Moser" (Vancouver Sun, Saturday May 24, p. A9).
equity between the hospital and community sub-sectors. The union printed leaflets for circulation at the NDP spring convention reminding the government of its commitment to the unions representing community health care workers \(\textit{Vancouver Sun,}\) March 25, 1997; p. B2).

In 1998, with the expiry of the 1996 legislated collective agreements, first HEU, then BCNU, and at year-end, the H.S.A. called strikes. Those strikes were engineered not to put pressure on employers, but directly on the government. They were waged through the media, and centred on inadequate funding and inadequate staffing levels in institutional health care services. Those strikes thoroughly disrupted hospitals over the autumn of 1998 and the winter of 1999. Medicare was back in its familiar state of crisis over familiar issues. The original purpose of restructuring was now little more than a background issue.

6.4 Implications for Contemporary Health Care Politics in B.C.

Between 1993 and 1998, health care policy was re-framed from a community health reform to a funding quest on behalf of traditional health care providers. That re-framing was evident as three successive crises wracked the provincial health care system. The first was the rural physician crisis; the second was the broader physician fee dispute; the third was the crisis in hospital, diagnostic and continuing care services.

The rural physician crisis (and the physician fee dispute in which it was embedded) surfaced and proved to be so intractable because of three interpretative (or ideational) elements and an action (or strategic) element. The interpretative elements comprised government’s antipathy towards professionals, their set of beliefs supporting the conclusion that physicians’ activities were the key to health care costs, and their incorporation of elements of a community health perspective. The B.C. provincial government’s attachment to an interpretive frame containing those interrelated values and beliefs made negotiations with the medical profession, who saw themselves as the legitimate providers of needed patient care, problematic. Contributing to the impasse were the strategic exigencies – in particular the conflict between physician demand for additional resources and government’s commitments to other spending priorities (including job protection and wages for unionized health care workers).
6.4.1 Closer to Home: Services to Rural British Columbians

B.C. experienced growing concern regarding the availability of medical services to rural communities over the eight years following the barrage of complaints to the Seaton Commission. The experience of neighbouring Alberta was illustrative of opportunities that could have been exploited had the B.C. government and medical association frames not diverged so dramatically. In contrast to B.C., whose rural communities continued to lose doctors, Alberta was relatively successful in recruiting and retaining rural physicians.

Beginning in 1991, the Alberta Ministry of Health partnered with the Alberta Medical Association, the two medical schools in the province, and the new regional health authorities. Approximately $2.8 million was allocated annually (enhanced by an additional one million dollars in 1998) to improving professional development opportunities, housing, community supports for the physician and the physician’s family, weekend and vacation relief and other measures. Curricular changes within, and practice placements from, the medical schools were an additional part of the comprehensive rural physician programme. Importantly, fee schedules were also changed to recognize the financial and personal burden of on-call responsibilities in remote practice settings.

B.C. emulated some of Alberta’s initiatives. For example, the Faculty of Medicine of the University of British Columbia encouraged family practice rural placements. However, the key collateral developments such as curricular change and recruitment of rural students were slow developing. More significant, no effective partnerships and no coordinated strategy gelled. The primary reason was the NDP government’s steadfast opposition to paying the physicians more money, whether in terms of fees or benefits.

Thus in B.C. in 1998 rural communities continued to lose doctors whereas in Alberta 56 new ones were recruited to small isolated towns and villages. To some observers, this result was seen as strategic. The B.C. government, from the tabling of the Seaton Commission Report onward, made no secret of its desire to replace small rural hospitals and medical practices with community health centres. That action frame reflected community health beliefs, the NDP’s prejudice against doctors and understandings regarding the causes of rising health care expenditures. It also reflected the influence of academic and nursing lobbies within the NDP government. It certainly did not reflect the

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195 CBC radio, Kelowna Daybreak Program, 07:15 January 04, 1999. This is not to say that Alberta’s rural physician programme was completely successful. “Despite the fact that some provinces (e.g. Alberta and Ontario) have developed relatively comprehensive packages of initiatives to address this issue, it would appear that no policy package current extant in Canada can claim success” (Barer, Wood and Schneider, 1999; p. 38).

196 On May 14, 1998 the BCMA made a press release entitled “Does the NDP have a hidden agenda when it comes to northern and rural medicine?” The media release claimed the government was secretly pursuing a model based on nurse practitioners and salaried doctors. Dr. Avery, the BCMA president, was quoted as saying in the context of government’s refusal to pay on-call fees to rural doctors “What we are seeing here is a perfect example of northern and rural versus southern and urban: unequitable and rigorously rationed” (BCMA, 1998f)
views and express wishes of rural residents. Rural and northern communities continued to aspire for their own doctor and health care facilities, and were solidly backed by their local governments.

As was the case earlier with regionalization, the NDP government found itself squared off against municipal governments. Like that earlier case, the provincial government attempted to de-politicize the conflict between itself, the rural municipalities and the doctors through constructing a stakeholder group. And like the Governance Task Force before it, the Northern and Rural Health Task Force broke up in disarray, this time due to the intransigence of the provincial government over the issue of providing more money for rural doctors.

Shortly after the breakdown of stakeholder talks, the rural physician work stoppage erupted. In its immediate response, the government blustered and accused the medical association of malfeasance. Minister MacPhail held fast to her claim that the dispute was about money, not patient care. She refused to consider providing any new funds for medical services (MOH, 1998a, b, c). A month later, the new minister, Penny Priddy, called upon doctors to “respect their contract” and to desist from withholding services from patients (MOH, 1998d). She held fast on refusing new public money to support rural medical practices. A month later, facing continuing negative publicity, Priddy agreed to talks with the BCMA (MOH, 1998e). A few weeks later, she announced the appointment of health care consultant Lucy Dobbin to make recommendations aimed at solving the dispute. Temporarily gone was the heated rhetoric, and Priddy’s April 23 statement conceded “Dobbin’s mandate includes recommending new funding” (MOH, 1998f).

The Northern Rural Doctors Group responded to the government’s peace overture on April 29: “People are suffering and being denied adequate health care and the government’s attitude is scandalous” (BCMA, 1998d). The exchange prompted opposition Liberal Leader, Gordon Campbell, to call for an emergency debate in the legislature.

When Dobbin finally tabled her report, the government agreed to provide cash payments for stand-by coverage in rural communities. All of the report’s recommendations were endorsed, and the doctors went back to work. However, incoherence amongst, and the costs associated with implementing, the Dobbin recommendations gave government pause. By August, the BCMA was claiming the government had reneged on the deal with rural doctors, and the rhetoric and job actions heated up once again (BCMA 1998 g, h). Consequently, emergency rooms closed in the towns of Golden, Armstrong and Hundred Mile House (BCMA, 1998i,j). The political price to the government was high. The failure of the rural and northern health policy disaffected the resource extractive communities and the unions representing workers in those communities – the backbone of NDP electoral support.

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197 See Barer, Wood and Schneider (1999) p. 48 on problems of coherence within Dobbin’s report.
Alberta's provincial government, in contrast to B.C.'s, took a more instrumental posture towards organized medicine. While Alberta's government was as motivated as B.C.'s to constrain health care costs, it held a different policy frame— one much more congruent with the physicians and rural residents. Consequently, the problem of sustaining rural medical practices could be negotiated and problem-solved. The pro-business posture of the right-wing government in Alberta, and its action frame of providing publicly supported infrastructure to communities to aid private economic development, provided enough common policy ground to work out partnerships with doctors and communities within compatible (albeit not entirely consistent) policy frameworks.

The policy frame adopted by the NDP drew on interpretations promoted by the academic policy community (in particular the perspectives of welfare economists Reinhardt, Evans and Maynard regarding physician determination of the shape and size of health care expenditures). Those interpretations fit reasonably well with the community health perspective from which the NDP policy frame also drew. However, it is not clear whether the frame served as a true interpretative and action frame informing government policy or, alternatively, served mainly as a rhetorical device.

The attraction of community health ideas and actions certainly owed something to baser motivations on the part of government. The NDP was a populist party, left of centre, and naturally antipathetic to the privileged in general and doctors in particular. Many of the politicians and government advisors were trade union leaders who had honed an adversarial posture towards private business people and private practice professionals. Penny Priddy, the health minister during the exacerbation of conflict between the BCMA and the government, was a nurse with close ties to the BCNU and considerable professional hostility towards doctors.

At first blush, these observations open up two possibilities. The first is that the NDP espoused, when convenient, the health reform frame because it aligned better with their labour union constituency and their interest in constraining payments to doctors. In this rhetorical use, support by nurses would be expected. The second possibility is that the government's thinking and actions were actually informed by the policy frame.

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198 Alberta's government also battled the medical profession throughout the 1990's over fees, arguably more successfully than B.C.'s government. The dispute between government and profession in Alberta, however, was a purely distributive one, amenable to pluralist analysis, and characterized by ongoing negotiations between the parties. In short, it took the form of collective bargaining. B.C.'s medical politics, in contrast, had a distinctive ideological cast. More than money, specifically the role, authority and prerogatives of organized medicine, were at stake. Hence the intractability of the disputes in B.C. and the lack of success of either party— government or profession.

199 In her role as Minister, Ms. Priddy actually joined the striking nurses on their picket line. From that picket line, she publicly pledged government support for BCNU's members. The real employers of the nurses (who were in negotiations at the time) were neither involved nor consulted. Her actions with regard to nurses stood in stark contrast to the name-calling and confrontational tactics Ms. Priddy took with doctors.
To phrase the matter in such a fashion, however, is misleading. It suggests that either a “power explanation” or an “ideas explanation” is called for. As the second chapter demonstrated, a synthetic view that recognizes that interests and strategies to pursue them are inevitably established in the context of some frame is much more satisfactory. The question then becomes which frame is an actor implicitly holding, not whether or not s/he is holding one. Putting the matter in those terms does not, however, preclude rhetorical use of ideas. Rather, it aids in understanding it. An actor has an interpretative frame, an action frame and a rhetorical frame (Shon and Rein, 1994). The last, the strategic use of ideas, may or may not be consistent with the interpretative and action frames. If it is inconsistent, the actor is not behaving consistently with his/her real beliefs, values and goals. In short, s/he is behaving cynically.

The idea that that the community health frame was actually only a rhetorical frame for the NDP raises the question of what, then, was their interpretative and action frame if not the community health one? It also raises the question of why did the government adhere so stubbornly to it over its two terms in office when the political costs were patently so high?

The community health frame ensured conflict with doctors whose own frame was inconsistent with it. By its nature, that conflict was intractable – beyond negotiation. Only if the parties could agree on a new synthetic frame which in turn would redefine the nature of their interests could policy agreement be arrived at. Such an outcome was wholly unlikely since the medical practitioners and health care providers were situated within institutions with lengthy histories and powerful norms.

When the policy controversy spilled out of the bounds of the policy community and into the general public, politicization escalated. Once in the public domain, the debate over access, waiting times, waiting lists and quality of care worked systematically against the government. As politicization escalated, the government did behave more cynically. In order to salvage some credibility with the electorate, it blamed the federal government, local governments and the doctors for the health care crises, while it simultaneously pumped more money into the system. Because it had nothing less to lose, the government did hold out on “uncapping” payments to medical practitioners. By 1999, those partially capped medical fees joined strengthened unions and under-resourced regional authorities as the significant artifacts of the 1993 health reform initiative.  

6.4.2 The Fee Dispute

The Working Agreement, an accord between the BCMA and the government pursuant to the 1993 Master Agreement, committed the BCMA to a cap on the total available amount of government funding for insured medical services. Specifically, fee increases were tied

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200 In February 1999 the government restored the medical fees it clawed back. However, the gesture did not bring about an immediate end to the doctors’ work stoppages.
to utilization. Should the latter (service use) rise to the point where the government's allocation to medical care was exceeded, fee levels would be "clawed back" temporarily.

By 1997 utilization levels engaged the claw backs. The BCMA interpreted those claw backs, although in accordance with the Working Agreement, to constitute refusals to pay for all services rendered. Consequently, it called upon its members to reduce the number of services provided by declaring "reduced activity days" – in effect, work stoppages.

According to media reports, the parties agreed on the facts in the dispute. However the interpretation of those facts varied. The reported facts were:

1. spending on physicians services declined as a proportion of provincial revenue from 9.0% in 1992 to 7.6% in 1997;\(^{201}\)

2. the difference between what government paid and what would have been paid under conventional fee-for-service arrangements, between 1995 and 1998, amounted to approximately two-hundred million dollars worth of physicians' services;

3. payments were clawed back by 2.9% in 1997 and 4.4% in 1998 (\textit{Vancouver Sun}, Saturday August 8, 1998, p. A21).

The BCMA interpreted the facts to mean that government was off-loading the cost onto the physicians of providing services to a growing (and aging) population. The government interpreted the facts to mean the doctors were providing more services than were strictly necessary – \textit{i.e.} were failing to dampen utilization in accordance with the Agreement. The BCMA chose to reduce utilization to match government funding targets by staging physician office closures.

The office closures occurred throughout 1998 and were extended into 1999. None of the dire consequences (avoidable deaths and other catastrophes) attended the job action, mainly because physicians were careful to manage emergency back-up services. Emergency rooms were additionally burdened and senior citizens, parents of young children and the chronically ill were initially alarmed. But the reduced activity days (RADs) soon fell into a routine. The government refused to negotiate, and simply reiterated it had an agreement with the physicians. However, mounting bad publicity led government to launch, at the end of September 1998, an advertising campaign accusing the doctors of violating the Working Agreement and putting their financial interests ahead of their patients. In early October 1998, the BCMA responded in the province's newspapers with advertisements blaming health care shortages on government "sweetheart deals" with the unions.\(^{202}\) Similar advertisements showed calculations of how many medical services could be purchased for the price of the government's "doctor bashing" advertising campaign.

\(^{201}\) The BCMA regarded the reduced share of revenue, as well as the decline in per capita spending, as evidence of under-funding. The government regarded both as artifacts generated by the broader pattern of public spending.

\(^{202}\) The campaign was launched with a press release on October 05, 1998 (BCMA, 1998k).
Government and BCMA rhetoric grew very heated throughout the autumn of 1998. The Minister, Penny Priddy, said "I regret the ongoing B.C. medical association campaign to get more money by locking out patients". She claimed RADs were "about increased funding for doctors", further proof that the BCMA "puts doctors' incomes ahead of patients' interests" (MOH, 1998c). By February 1999, it was evident the government was losing the propaganda battle. Premier Clark signalled his government's willingness to restore fees to their full level. The BCMA responded that the belated move was too little too late and refused to call off future RADs.\(^{203}\)

6.4.3 Access, Waiting Lists and the Quality of Care

Along with the new limits on payments for physicians, the government cut hospital spending between 1992 and 1997.\(^{204}\) The government's figures show the proportion of hospital spending to government revenue falling from 18.3% in 1992 to 15.5% in 1997 - a significant change especially since the economy was in recession. The government also exceeded the Seaton Commission target of 2.75 acute care beds per 1,000. The ratio had dropped below 2.25/1000 by December 1998.\(^{205}\) Age-adjusted real per-capita funding for acute care declined 7% between 1991 and 1998 (HABC, 1998). Capacity in facility-based long-term care and home care, however, had not been increased to match the acute care reductions. As a result, the government reported that more than 75% of the patients in some provincial acute care hospitals could be more appropriately cared for as outpatients, in long-term care or rehabilitation centres, or through home care if the services existed.\(^{206}\) In short, services were, by 1998, no closer to home. The problem at the centre of the Seaton Commission Report -- inadequate alternatives to institutional acute care services -- was no closer to solution.

Worse from the government's perspective, the twin issues of wait lists and the downloading of costs onto patients and family caregivers grew in public prominence throughout 1998. The BCMA promoted through posters, petitions and letter-writing campaigns the notions that wait lists and waiting times for critical, urgent and elective procedures were growing and patient access to necessary services was diminishing. The doctors' RADs combined with union work stoppages and hospital reduced activity days (partial closures and cancellations of elective procedures due to staff shortages, budget shortfalls and the shortened work week granted to the unions through provincial bargaining) to feed a public perception of mounting accessibility problems. Meanwhile, the Family Caregivers' Network was effective in disseminating the message that

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\(^{203}\) The BCMA president remarked: "We still have to deal with the fall out of a past decision to under-fund physician services" (BCMA, 1999).

\(^{204}\) Some of the reduction is an illusion since extended care was transferred out of the hospital budget area and into continuing care in an effort by government to show a bigger transition to community based services than actually occurred.

\(^{205}\) This amounts to 2,130 beds less than recommended by Seaton.

\(^{206}\) See "Over half of hospital beds in B.C. wasted, study says" (Vancouver Sun, Wednesday, March 17, 1997, p. A8).
hospitals save money through transferring the costs of care onto family members in the context of an underdeveloped and underfunded home care and community health service.\textsuperscript{207}

Wait lists for diagnostic and treatment services led the Workers’ Compensation Board and some private companies\textsuperscript{208} to purchase capacity idled by public funding constraints. That in turn provoked an angry response from health care unions to the effect that reductions in public funding were incubating a two-tiered health care system.

In April 1998, the BCMA released its first wait list report (BCMA, 1998c). In December 1998, it was followed by \textit{Waiting List II} (BCMA, 1998b) which claimed to document an eight week median wait for emergency neurosurgery and a six week median wait for urgent breast cancer surgery.\textsuperscript{209} Ranges extended up to twenty-eight weeks for emergency brain tumor surgery. While the Minister refused to consider the $198 million “top-up” funding the BCMA said was needed, she was forced to concede that the wait lists were too long and more money was urgently needed.

The agitation by doctors had profound effects. A Globe and Mail/Angus Reid poll reported on February 6, 1999 that the proportion of Canadians ranking the health care system as excellent fell from 26\% in 1991 to 7\% in 1999. The proportion ranking the health care system as poor jumped from 3\% in 1991 to 17\% in 1999. In B.C., 53\% (compared to 51\% nationally) blamed the provincial government for the worsening quality of health care services. The NDP’s strategy of blaming the federal government’s cuts to health programmes’ transfer payments was not working – only 24\% of British Columbians believed the federal government was at fault (\textit{Globe and Mail}, Saturday, February 6, 1999; p. A10).

The situation by the spring of 1999 paralleled that of ten years earlier. The public blamed both the BCMA and the provincial government for declining service levels, adversarial posturing, and mismanagement of an essential service. Both the provincial and federal governments, through their 1999/2000 budgets, committed themselves to infusing massive amounts of new funding to quell public discontent, particularly with respect to acute care services. There was no more talk of health reform.

\textsuperscript{207} See, for example, the full page article in the \textit{Vancouver Sun} “Welcome to care in the fast lane” (Tuesday, August 11, 1998, p. A9).
\textsuperscript{208} For example, Teck Corporation purchased diagnostic and treatment services for its Tumbler Ridge mining operation.
\textsuperscript{209} The BCMA reports were issued in response to the November 1997 B.C. Ministry of Health \textit{Waiting List Report}. The reports were components of a propaganda battle between the government and the BCMA. Extensive media advertising followed the release of each report.
6.5 Implications for Accountability

During the critical three years between the 1993 birth of *New Directions* and its funeral rites in November 1996, the British Columbia government’s position on elections, taxation, local autonomy and scope of action for health authorities changed. The direction of change in each instance was consistent with the progressive abandonment of the reform principles inherent in the original policy statement. Movement was away from a perspective centred on citizen empowerment toward a policy focussing on the accountability of boards and councils to the Ministry of Health. Bound up in that change was a retreat from political accountability to the community and an advance toward managerial accountability to the ministry.

The changes were not merely organizational, nor were they merely the result of conflicts between the goals of improving health system management and improving the accountability of health service professionals and providers. They marked a change in policy. Local accountability and community empowerment are bound up conceptually and normatively with a perspective on health, a position on the role of health services, an interpretation of the position of health care providers, and a view on accountability. Each of these elements also relates to the interests of the different constituencies such as health care unions, health professionals and managers.

The changes are also bound up with issues of power and control. In principle, there can be no accountability without control. A body cannot be held accountable for something that is beyond its power (Day and Klein, 1987). Accountability also requires that those to whom a body is accountable have the means to hold that body to account. Holding to account entails several conditions, chief amongst them knowledge of the actions taken and the reasons for those actions. Holding to account also requires, in principle, the prospect of sanctions by those to whom accountability is owed (Klein, 1993).

Citizen boards were explicit attempts to make health professionals, providers and managers more accountable to the public. Accountability to the public requires transparency of board processes, full disclosure of the board’s actions, reasonable public notice of meetings, opportunities for the public to seek reasons for the board’s actions, as well as ready public access to background information. Those basic conditions were recognized at the outset by the government and were mandated in directions given to interim boards and councils (MOH, 1994q).

However, those basic conditions are not jointly sufficient for accountability to the community. They do not assure adequate board control over the areas it is formally responsible for, nor are they jointly sufficient for the public to hold the board to account. Election of board members is important in this context. Elections serve not only to increase the legitimacy of the board members in the eyes of the public and the health care providers, but also increase the accountability of board members to the local citizenry. Enhanced legitimacy enhances authority, which in turn strengthens control. Elections
also force the giving of reasons, explanations of actions by incumbents and rationales for planned actions by aspirants. Further, elections give the public a means of sanctioning board members by defeat at the polls.

While a policy of community development and community health would suggest public elections of boards and councils (reserving room for some appointments to ensure all key constituencies were represented), the government first deferred then abandoned the idea of elections. There were several reasons for the reversal, as outlined earlier in the chapter. Foremost amongst them were:

(1) government’s concerns that the general public would support traditional health care services and their providers;

(2) the government’s concern that low election turnouts could allow capture of boards and councils by special interest groups such as anti-abortionists;

(3) the growing concern by government and managers over their control of the process; and

(4) government’s shift in health goals and perspective on health service.

The change to fully appointed bodies had several implications. First, political appointment blurred the function of boards with the responsibilities of government through the creation of relationships of agency and subsidiarity. Apart from the appearance of patronage (and political motivation more broadly) created by ministerial appointment, the approach linked the board member to the Minister, and thereby to the Minister’s responsibilities to Cabinet and the legislature. From the perspective of administrative law, the member was in an agency relationship to the Minister. The appointed board as a whole reflected the principle of subsidiarity – it was the creature of and was accountable to government. In short, authority was not devolved to the boards and councils, as it would be through the principle of public elections, but delegated to them by the provincial government.

In addition to the principle of appointment, there were issues of practice. What criteria should be used for the selection of board members and how could they be defended as legitimate? In this regard, the B.C. auditor general, George Morfitt, criticized the government for having no rational criteria for selection. He commented “there was no documentation to identify competencies required by each individual or the governing body as a whole”. Without it Morfitt concluded, there was no foundation for board accountability (Morfitt, 1998).

Board members were not only drawn into politics. The approach under Better Teamwork drew managers into policy. The “new public management” called for appointing visionary leaders as chief executive officers, thereby blurring management’s role with

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See also McLintock (1998) who reported that board positions were filled on political whim.
that of the board. The “Carver Model” of board governance (imposed by the ministry on the boards) offered an expansive role to the chief executive officer, and a truncated one for the board (Carver, 1990). It facilitated the migration of management into governance, while enjoining boards to steer clear of management. The model rested on the faulty assumption that governance is about normative matters whereas management is technical and “values-free”. The public role of CEO’s, their role in the distribution of resources, and their responsibility for organizational climate are all inherently normative. They “are not only or simply aspects of the managerial repertoire, but are fundamentally concerned with the allocation of values” (Harrison and Nutley, 1996, p. 243). In short, a government appointed board operating under the Carver model was encroached upon from both the political and managerial sides. Such boards have the misfortune of occupying what Anne Mills described as the “twilight zone in public administration” (op.cit. Mills, 1993).

The government’s growing emphasis after February 1994 on accountability for the results of health care spending exacerbated the issues of board accountability and control. The subordinate relationship to government and the emphasis on improving health care management operated hand-in-hand. Jointly, they reduced the board’s public role in two ways. First, they limited public consultation partly because of the risk of consultations leading to conclusions inconsistent with government’s preferred direction and partly because the public has little to offer with regard to improving management outcomes.211 As Ham and Best put it (in the context of the National Health Service’s drive to outcomes-based cost-effectiveness), emphasizing the quality of health care management “means downgrading [the board’s] role in providing a channel for public participation” (Ham and Best, 1990; p. 483).

Accountability to the public requires clear, publicly supported principles and goals. Those would normally be defined and gain legitimacy through local democratic processes, including elections of governors. The decision to appoint board members rather than elect (the majority of) them placed an enormous responsibility on the new boards to develop effective participatory mechanisms. Unfortunately, the narrow view of the governing bodies’ role – improving management – makes both the idea of and mechanisms for consultation problematic. The context for implementation made matters even more problematic – community activists and volunteers had been either sapped of energy or thoroughly alienated by the disintegration of New Directions.

Successive Ministers of Health had striven to use their powers of appointment to create boards that contained a cross-section of people from the community, with special attention paid to minorities such as aboriginal people. While appointees were drawn from distinctive groups, they could not be said to represent them. There was no

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211 As Saltman pointed out, citizens, qua patients and consumers, tell managers and governors what they want, but that casts no light on what is needed. If it can be assumed the public wants more and better quality services, consulting, when the object of the exercise is to provide less, is disingenuous. Seeking public guidance on how to provide less would also be a mistake, as that is a technical question. Consultation reduces to determining which technically feasible option to achieve the predetermined goal is least objectionable. On the subject of concepts and principles of consultation, see Saltman (1994).
connection between board members and their “constituencies”. Board members
themselves regarded their role to be representative of the broader region (as they were
enjoined to do under Better Teamwork). However, as Day and Klein noted, without
specific mechanisms of consultation the claim to represent the community is an empty
one.

Taxing authority is closely linked to the elections and both relate to accountability. Taxes and elections are linked by the constitutional principle of no taxation without representation. Taxation is linked to accountability by the public administration principle that a public body can only be fully accountable for spending if it has some responsibility for raising its own revenues.

Central governments everywhere are reluctant to give local authorities taxation powers other than property taxation. There are three reasons. First, governments do not wish to cede tax room to subordinate bodies. Second, property taxes are more readily set and collected locally because local conditions and property values vary. Third, property taxes are highly inelastic, and therefore do not give local authorities much capacity to expand public spending. However, property taxes are also charged politically, and suggestions to change who may levy them at what rates are bound to be controversial. That was certainly true with the proposal that RHBs raise the 40% of local revenues required for hospital projects. The resistance by local government eventually forced the provincial government to back down.

The reversal brought fresh difficulties. The media claimed disconnecting spending and revenue powers undermined the accountability of health boards. “The people appointed to the new boards by the NDP government are now responsible but not accountable” (Lamb, 1995). Academic observers concurred. Severing the link between health service provision and local taxation was tantamount to converting the health boards into agents of the government (Abelson, et.al., 1995). Most vocal in this regard were the same local governments that opposed fiscal independence for boards and councils:

The Province appears to be delegating responsibility for health care to communities but is retaining control over the expenditure of funds. This has the potential to create a situation that everyone wants to avoid; that of no clear accountability or responsiveness to either provincial or local priorities. This can produce a situation wherein:

- local health bodies avoid being accountable to local publics by simply stating they did not receive adequate provincial funding to meet local priorities

See in this regard Lomas, Jonathan, John Woods and Gerry Veenstra (1997), whose Canadian survey work found board and council members generally regarded themselves as representing the broader constituency of their community or region. Day and Klein (1987) found a similar perspective amongst (appointed) health board members in the United Kingdom. For the Okanagan Similkameen Board’s perspective, see supra, pp. 181-184.

Mills (1990) argued that elections and taxation powers are both necessary conditions for devolution of power. Regionalization without devolution amounts to administrative delegation or deconcentration.
• the Health Minister passes the responsibility to local bodies by saying that adequate funding, or the maximum available funding was provided for local priorities. (UBCM, 1996, p. 2).

Local autonomy also contracted sharply over the course of New Directions’ implementation, and virtually vanished with Better Teamwork. The encouragement of local diversity and experimentation in the context of substantial community control was replaced by a focus on narrowly defined core services, outcome measures, and the accountability framework. The shift was from what Klein called “political accountability” to managerial accountability” (Klein, 1993).214

The range of programmes and services for which the boards were responsible also shrank over the three-year implementation period. Following the creation of the Ministry of Children and Family Services, the scope of programmes was even smaller than the pre-reform cluster of Ministry of Health programmes. It comprised only hospital, continuing care and some public health services. The potential for collaboration and new partnerships shrunk with the scope of services.

In consequence of these changes, boards were increasingly enjoined by the ministry from 1996 onwards to express their responsibilities in terms of results achieved by health care spending. This was quite different from articulating responsibilities in terms of results for people. The former was about efficiency and effectiveness of services, the latter was about aligning public expenditures with the needs of the community. The entire frame of reference changed from a political one to a managerial one. Expressed alternatively, the frame of reference changed from a community health one to a health care one.

The more emphasis that was placed on technical and managerial dimensions, the less the power and authority of the board and the greater the influence of management (Morone and Marmor, 1981). Consequently, the goal of holding management (and the providers) accountable to the public was subverted.

The embedded case examines the extent of that subversion to determine whether managers accrued power as a result of the health reform process, and, if so, the implications for the public and the health professionals. This question is bound up with the question of board accountability, because without the power to control the managers and professionals, the board cannot be held accountable for the services they are purportedly in charge of. That would hold true whether the issue was political accountability to the community or managerial accountability to the ministry. One task of the embedded case study, then, is to determine whether the boards have the power to be accountable in either respect.

214 Both Rhodes (1988, pp. 402-6) and Klein (1993) use the distinction. Political accountability refers to being held answerable for one’s actions – being held to account. It includes taking direction from and being sanctioned by those to whom one is accountable. Managerial accountability refers to spending money in accordance with accepted accounting practices, providing services as efficiently as possible, and obtaining the intended results. See also Day and Klein (1987) especially p. 27.
6.6 Politics, Legitimacy and Control

The primary case study of health care reform in British Columbia suggests a significant role for political factors. The first factor is the instability of the government side over the period of the reform; the second relates to style of government, and the third relates to legitimacy and control.

The five years of active reform effort were overseen by no fewer than five ministers (Cull, Ramsey, Petter, MacPhail and Priddy), three deputy ministers and two premiers. Cull, Ramsey, MacPhail and Priddy had not only different levels of ability, but also different backgrounds, constituencies of support, styles and values. Ramsey and Priddy were regarded as weak ministers in an undesirable portfolio. Cull, a strong minister, failed in her bid for re-election. Petter had been only temporarily parachuted into the portfolio to put a lid on discontent in the run up to the 1996 election. Premier Clark rewarded MacPhail for her strong effort in Health by promoting her to Finance.

The shifting cast of senior public servants also displayed significant differences in attitudes and approaches. Those differences were especially obvious between McFarlane (1993 to 1995) and Fyke (1995 to 1996). The former, Lawrie McFarlane, represented “new public management thinking” in a career public servant closely associated with the NDP. The latter, Ken Fyke, had a lengthy background in hospital and health care administration.

At the very least, the instability in political and bureaucratic leadership made consistency in policy implementation nearly impossible. Given the organizational depth, stability and steadfastness of the institutional actors opposing elements of the reform policy – the unions and the BCMA – it is scarcely surprising the government’s position drifted.

The scandal over misappropriation of charitable funds that led to the resignation in 1995 of the first government leader (Harcourt) gave rise not only to a premier with a very different style and personal constituency (Clark), but also to serious blows to the government’s legitimacy. The first blow was to the moral integrity of a left-of-centre party caught misappropriating the funds of a charitable foundation. The second was the disclosure that the new premier misled the legislature and the public regarding the state of provincial finances in the lead-up to the 1996 election. That second blow provoked an attempt to unseat (through recall) the Minister of Health (Ramsey) and an attempt to overturn the election through court challenges. It also led to an investigation by the provincial Auditor General into the NDP’s budget and planning processes. By February 1999, the B.C. provincial government and its premier had the lowest public support ratings of any Canadian provincial government.

From a governing style point of view, Clark was much more like Vander Zalm and Bennett – populist, mercurial, and personal in his style of government. That contrasted with Harcourt who valued procedures, process and public involvement. Clark was an ex-
union organizer with close personal ties to the B.C. Federation of Labour. Harcourt was an ex-mayor of Vancouver and reasonably well connected to business as well as labour interests. The broad-based consultations of the Harcourt years were by and large replaced by selective stakeholder consultations under Clark.

The public widely regarded the Clark government as illegitimate following the narrow 1996-election victory. Anger over the misleading picture given of provincial finances prior to the election was compounded by the provincial economy going into free-fall. By 1997, the B.C. economy, in contrast with other provincial economies, was in an economic recession. As in 1973, the NDP government was held responsible for the perceived economic difficulties. Pundits claimed that the NDP’s labour-friendly policies, “insider deals”, and fiscal incompetence had once again brought the province to economic ruin.215

Given the premier’s style and the crises erupting around it, the Clark government was pre-occupied with control. This was not an entirely new preoccupation. As was noted earlier, the Harcourt government retreated from the prospect of an independent provincial medical officer and a provincial health council that reported directly to the legislature since both threatened ministerial and cabinet control. The difference was a matter of degree. The government under Clark showed definite signs of “reform interruptus”216. The effect is the result of injecting corporate management thinking into government, in particular the fashion amongst labour governments for “tight/loose control”.

Soft left governments, such as the Blair government in the U.K., shared with the NDP in British Columbia a “corporatist populist” perspective. Corporate populism attempts to manage important actors such as cabinet, caucus, labour unions, business groups and other institutionalized formations as “stakeholders”. That is, its practitioners treat institutional actors as though they are part of a single corporation. The object is to create the impression both within and outside government that the lead politicians are managing the social enterprise on behalf of voters who, from this frame, are transmogrified into customers or clients. It models itself not on the small competitive firm functioning in a relatively free market, but on the order and control of the huge corporation. It aspires not to meet consumers’ needs, but to shape their demands – anticipate consumer desires before the consumers themselves.

This interpretive and action frame has been argued to describe the thinking, values and actions of U.K. Prime Minister Tony Blair (Barnett, 1999). It is just as fitting of the style of government found under Clark. In the context of health care reform, the diversity and fluctuations in service levels that would attend local autonomy would attract considerable attention and management intervention. The process of corporate management would drive selection of, set standards for, and provide guidance to regional health boards. Those in turn mean greater and greater micro-management of the details of health care

215 National Post, Saturday March 20, 1999 pp. B-4, B-5. The public’s rating of B.C. provincial health care policy was also the worst in Canada – somewhat surprising given the right-of-centre governments in office in most Canadian provinces (ibid.).

216 “It starts in stirring fashion, then pulls back from making the connections and fails to deliver on the spirit of the reform, leaving expectations aroused but not satisfied” (Barnett, 1999; p. 26).
delivery. It is a mindset that stifles effective health care, patients “being neither products nor consumers” (ibid. p. 29). The end result is the oxymoron of “controlled devolution” – a species of “reform interruptus”.

Apart from political factors relating specifically to the provincial government, the role of the Union of B.C. Municipalities in wrecking the health care reform was also essentially political. The controversy over regionalization was a classic dispute between two levels of government over their respective authorities and taxation powers. Municipal governments siding with the Hospital Association and the BCMA reflected essentially opportunism – a coalition of convenience intended to protect local hospitals and local jobs.

The loss of the government’s legitimacy played an important role in government’s confrontation with the BCMA, especially regarding the issue of waiting lists.217 By 1998, the government was simply not credible on any policy front. Not only health policy, but also forestry policy, economic policy, fishery policy and environmental policy were in tatters. The public held the government to be as much to blame for the problems in the health care system as the doctors and other parties beyond government control.

In the case of the unions, BCNU managed through careful public relations and staged industrial actions to maintain, and perhaps even build, the credibility of, and public sympathy for, their members. That was achieved in spite of the prolonged labour dispute between nurses, their employers and the government. It is unlikely BCNU could have scored a public relations victory, and managed to advance the proposition that more staff and money were so desperately needed, if the government and the government’s position were seen by the public to be more credible.

Despite the government’s efforts at control, it lost the initiative over health care reform. Control of the policy discourse and the policy agenda returned to the health care unions and the BCMA, at least in part as a result of classical political variables. By 1998, a reversal in legitimacy had taken place. In 1991, Seaton could confidently advance government’s case by impugning the legitimacy of health care providers and professionals; seven years later it was government’s view that lacked legitimacy.

217 Curiously, the credibility of physicians seemed to rise throughout the 1990’s while that of government continued to fall. A Mori Poll showed public trust in physicians rose from 82% to 91% between 1983 and 1999, reversing 15 years of decline. (Prospect, 1999, p. 4).
6.6.1 Who Won? Who Lost?

Unionized health care workers were big winners as a result of the developments between 1991 and 1999. While most provincial governments had edged towards privatization and de-insurance in the 1980's, the health care system in B.C. emerged unequivocally “single tier” and publicly funded at the end of the 1990's. Private health care was fenced-in by new provincial legislation. Through the 1999/00 budgets, federal and provincial governments pledged significant new money and jobs. The working conditions of nurses and other health care providers were firmly on the policy agenda. Public attention and support were high for issues important to nurses and allied health care workers. Health governance bodies that had been regarded as pawns of the doctors (i.e. hospital boards of trustees) had been abolished. By 1999 all B.C. health governing bodies were appointed and included representation from the unions. The CHCs with their potential for community control and diversity of employment practices were gone. The unions’ positions were institutionalized in provincial collective bargaining structures that significantly strengthened the control they exercised over their members (and the locals to which they belonged), as well as significantly diminished local employers’ rights.

On the face of it, doctors came out less well. They suffered a significant blow to their reputation as a result of the longstanding quarrel with government. Their management of public relations was not successful compared to the nurses. Besides more lucrative arrangements with the Workers’ Compensation Board, few avenues for alternative funding opened up. On the plus side, doctors won the battle over health care governance. CHCs were abolished. Community health centres that would cast doctors into staff roles were still talked about rather than established as alternatives to fee for service medicine. No moves had been made in the direction of population-based funding for primary care. In response to medical and union agitation, the public was forcing governments to pump more public funds into hospital, diagnostic and treatment services. Even more important, the public was fed up with reform efforts, which were now widely regarded as cynical moves to cut services and off-load costs. By 1999, the health care frame was the only legitimate frame – medical ideology was again triumphant. The health policy agenda was again the health care services agenda.

The remarkable thing is how much ground doctors retained. Their professional prerogatives emerged intact from “the decade of reform”. Scopes of practice were not narrowed, professional oversight was not appreciably strengthened, and clinical guidelines were both voluntary and ineffectual. Physicians sat on, and exercised

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218 In fact, local and regional employers were effectively abolished by the legislated formation of HEABC.

219 The doctors were not alone in terms of clinging to their historic professional prerogatives. The 1995 scopes of practice proposals that would have seen a larger scope of practice for licensed practical nurses went nowhere because the Registered Nurses Association of B.C. lobbied to retain control over “reserved acts”. Thus in 1999, as in the pre-Seaton period, LPNs and care aides could only provide care under explicit RN delegation.
considerable influence over, the new governance bodies. Medical expertise was unequivocally involved at all levels of health service management and governance. Physician incomes held their own, and aside from the minor case of midwifery, no one else was seated at their “health care feast” (op. cit. Reinhardt). However, the level of fee payment and the profession’s right to determine relative values of services rendered under medicare remained sore points, as they had in B.C. since the inception of medicare.

While health care managers were excluded from stakeholder consultations, they recreated on the ground regional structures and operating norms that pre-dated the reforms. Key personnel (hospital administrators, continuing care managers, and public health administrators) returned to executive positions over by-and-large unreformed programmes. Like the physicians, they “held their own”.

Health care advocacy groups, volunteer organizations and health reform coalitions were the big losers. They were frozen out of a process that institutionalized dealings with the major “stakeholders”. Organized provincially, they now had to deal with a host of regional bodies. Both those regional bodies and the ministry of health could safely ignore them by claiming the other governance level was the relevant point of contact. Under the new arrangements, local bodies lacked the capacity to respond to advocacy coalitions and the provincial government lacked the will. The expectations of advocacy organizations had been aroused by reform interruptus and they suffered the consequences of the government’s failure to deliver.

6.7 Factors Contributing to the Reform’s Failure

New Directions, as a comprehensive policy initiative, was not well thought through. The complex issues of delegation, devolution and accountability were worked out on the fly in the face of previous commitments and at the expense of alienating constituencies of support constellated around the public’s understanding of the government’s original position.

Inexperience and instability in the government contributed to confusion and inconsistency throughout the policy implementation period. Stunningly, the original policy model failed to recognize the principal feature of B.C.’s human geography – a conurbation in the lower mainland with the remainder of the enormous landmass populated by small, relatively isolated settlements. While community councils nested in

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220 The nature and degree of their influence at the regional level is assessed in the embedded case study.

221 Retention of earning power is a key indicator of professional power (Friedson, 1994; Mechanic 1994; Flynn, 1992). Individual doctor’s earnings from public medicare sources actually rose in B.C. over the period of “capped fees”. From 1993/94 to 1996/97 average Medical Services Plan billings per physician rose 6% for specialists and 9% for general practitioners (MOH, 1997).

222 The most senior managers, the new regional health authorities’ chief executive officers, did more than hold their own. The regional CEOs enjoyed command of larger organizations and earned higher salaries than their predecessors.
larger regions made sense for much of the interior of the province, the attempt to apply a multi-level governance model to greater Vancouver can only be explained in terms of the combination of ideological commitment and inexperience of the newly elected NDP government.\textsuperscript{223}

The government seriously underestimated the significance of structural power variables. It mistakenly concluded peace could be bought with the doctors and unions by constructing quasi corporatist arrangements to manage conflicts involving their principal material interests. There was no plan to deal with the violent objection in principle to core elements of the reform and no constituency upon whom the government could draw to support its initiative. The government also underestimated the significance of differences in cultures and norms between the unions and professionals on the one hand and between the different health sub-sectors (e.g. acute care and community health) on the other. "Although creativity is an important part of the framing process, so is the ability to project frames, once they have been built, to the intended audience" (Campbell, 1998; p. 397). Organizational resources and sympathetic allies are critical in this regard. The proponents of building more health care capacity prevailed partly due to their superior organization, but also due to their ability to play to public fears regarding reduced access to emergency and surgical services.

\textit{New Directions} embedded a tension between health policy and health care policy. The policy statement failed to reconcile improvements to the existing hospital and medicare system (the health care policy agenda of the Seaton Commission) with a broader view of health policy drawn from the community health perspective. The government failed to recognize the contradiction and consequently it failed to correctly assess the difficulty in forcing a transition from a public policy of health care to a public policy of health. That difficulty arose from the legal framework, institutional interests, and the capacity of those structural variables to condition public opinion.

The approach to management and governance was also curiously naïve. The government relied wholly on the existing managerial cadre for implementation of the reform and operation of the new health care system. It assumed the installation of a new leadership – the Boards – could effect systemic change at the local level. However, not even that leadership was systematically drawn – there were no selection principles, orientation and support were inadequate, and even the policy menu board members were fed through ministry documents and directives was eclectic. Inclusion in governance roles of past hospital board members (for their experience), local government officials (to appease municipal governments), and later employees and doctors meant the new "dictatorship of the proletariat" never spoke or acted consistently with the community health frame that informed \textit{New Directions}. The delays in getting boards in place and operational, in large part due to the commitment to the CHC/RHB model, meant the transition in leadership was protracted and ultimately ineffectual.

\textsuperscript{223} Ministry officials were well aware of the implementation problems the two level governance model would generate. They could not, however, discourage health minister Cull and premier Harcourt from the grass-roots CHC-based approach to health reform.
6.8 Primary Case Study Findings

The primary case study addressed the following questions:

How did British Columbia’s health reform policy – New Directions – differ from the health policies that preceded it? What ideological content did it incorporate? How and why did that content change over time, whom did those changes affect, and what was the significance of the changes? How are the perspectives incorporated in policy related to the perspectives of actors and coalitions engaged in the health sector? To what extent and in what fashion did the non-governmental and governmental agents interact? (infra. p. 2)

The study found that New Directions departed significantly from previous provincial health care policy which was framed around containing the costs of medical and hospital insurance through the application of conventional governing instruments such as incentives and regulations. It also departed significantly from the Royal Commission recommendations, recommendations that were essentially managerial. New Directions broke new ground by advancing a community health perspective, a commitment to community development and democratization, and the devolution of authority from the bureaucracy and health care providers to publicly elected community boards.

The ideology of New Directions was the ideology of community health. The policy consciously incorporated the “community health perspective”. It therefore shifted policy intentions away from health care services for individuals and towards outcomes for groups of people. That ideology conflicted with the prevailing health professional perspective on a number of critical fronts. New Directions was collectivist rather than individualist, it was concerned with outcomes rather than processes and it empowered communities at the expense of professional and provider. Unsurprisingly, it attracted considerable hostility from the medical profession and the health care unions.

The content of health policy changed dramatically from the inception of New Directions in February 1993 to its demise in November 1996. The participatory democratic content was progressively pumped out and replaced by organizational and managerial concerns. As government struggled to control the policy implementation process, it gutted the reform.

The changes in health policy favoured the dominant health care interests – the health care provider unions and the doctors. In the case of the state actor/union actor relationship, a quasi-corporatist arrangement emerged. The unions were treated as partners in the policy implementation process and thereby significantly influenced the outcomes. In the case of physicians, government chose to ignore them, essentially freezing them out of the process. The direct influence of physicians was not felt and the changes made between 1993 and 1996 were not in response to the doctors’ discontent. It was only after the gutting of the reform initiative and the post-1996 return to a more conventional health
care policy that the medical profession scored significant victories by mobilizing the public to demand more spending on health care.

The unions, the doctors and the government each brought identifiable perspectives to the policy process. The unions sought a bureaucratic, hierarchically arranged health care sector, centred on hospitals, supported entirely by public funds and managed by the provincial government. The doctors sought the retention of a health care system founded on private, fee-for-service medical practice -- a system that enshrined patient choice and clinical autonomy, and welcomed private sources of financing. The newly elected NDP government initially pursued a reformist, community health oriented policy, but soon reverted through a series of retreats and side-deals with various constituencies to the conventional welfare-state posture of managing the public financing of an integrated health care system.

Interestingly, the various parties did not form coalitions. They exhibited little in the way of coherent, coordinated action. By-and-large, the institutional actors operated within their ideological solitudes. Each, with varying degrees of success, tried to mobilize the public. In the end, the public reflected elements of the health professional and union perspectives. Both of the government's developed policy positions, New Directions and Better Teamwork, widely came to be regarded as cynical attempts to limit health care spending and public access to services by a government whose credibility and legitimacy plummeted. Public approval of the government's health policy fell from over 70% in 1993 to less than 20% in 1999. Overall public approval of the government fared even worse.

6.8.1 Implications for Theory

The traditional approaches found in the policy community literature\textsuperscript{224} fail to account fully for the dynamics of the health policy reform process uncovered by the primary case study. Apart from issues of coherence and theory construction discussed in chapter 2, a literature that characterizes policy processes in terms of coalitions and state/non-state interactions has no purchase over a real-world situation in which the evidence shows limited concerted action amongst the putative parties -- \textit{i.e.} situations in which the principal actors refuse to interact with each other.

One key finding in this regard is the absence of a coalition amongst the opponents of the B.C. health care reform. While the British Columbia Medical Association, the Union of B.C. Municipalities and the Liberal Party ensured that each other was apprised of press releases and position papers, they neither coordinated their activities nor in any significant sense shared beliefs, values and objectives.

\textsuperscript{224} That literature is critically reviewed in the second chapter, \textit{infra} pp. 18-50.
Like most observers prior to the 1996 B.C. provincial election, the British Columbia Medical Association expected the Liberals to form the next government. The BCMA, both in order to place pressure through the opposition on the existing NDP government and to establish lines of communication with the party they assumed would form the new government, ensured that the Liberal party was copied with BCMA press releases and position papers. The BCMA concluded, however, that it should not act in an explicitly partisan way. Its longer term objective of working with the state on issues of concern to doctors would be compromised, and so too would the legitimacy of BCMA’s claim to be a professional, neutral body, advocating not only on behalf of doctors, but also on behalf of the public.

The Union of B.C. Municipalities, an organization that caused the government considerable grief during health reform policy implementation, had no interest in the BCMA’s interpretative frame and shared almost no objectives with the medical profession. The UBCM was concerned with issues of governance, devolution and taxation – in particular, government off-loading costs and responsibilities to local authorities. The UBCM incorporated some of the BCMA’s rhetoric and supported some of the BCMA’s positions, but only because that advanced the UBCM’s agenda concerning local government. The UBCM also had more sympathy with the Liberals than the NDP, partly for ideological reasons and partly because of the self-interest of local politicians regarding what they saw as future electoral advantage. But that sympathy had nothing to do with the content or aims of health policy. In short, the UBCM was not part of a health policy coalition, nor even a member of the health policy network, but nevertheless proved to be one of the most influential actors.

The Liberal Party was cautious. The pre-election polls showed they would handily win the election as long as they made no major errors. The party adopted the position of government-in-waiting. It was therefore not prepared to lend support to doctors or to the municipalities who were opposing the NDP government’s health reform out of fear of compromising its own capacity to govern once elected. Instead, the Liberals lent tacit support to the government’s opponents and used their resources strategically to attack the credibility of the NDP.

The NDP government ignored the BCMA throughout the retreat from *New Directions*. It marginalized the BCMA’s role in the policy process. Further, the BCMA did not succeed in galvanizing the public who appeared indifferent to the entire health reform initiative until well after *New Directions* was in trouble. Government’s policy changes between 1993 and 1996 cannot reasonably be construed as a response to direct BCMA engagement in the policy process nor as responses to power politics – i.e. mobilization of opponents to the government’s position. The policy changes were consistent with BCMA demands, but certainly were not in response to them.

A second major finding is that no health care reform coalition lay behind the initial 1993 reform effort. In fact, the B.C. government was hobbled from the outset by the absence of any compelling reasons to reform the system. Costs were no longer rising beyond the

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225 The waiting list issue did not emerge until 1995 and did not become a full-blown crisis until 1998.
means to meet them, the economy was performing well, and no one (aside from some members of the academic policy network and elements in nursing) was lobbying for change. The Registered Nurses of British Columbia did lend support to New Directions, as they understandably saw reductions in physician dominance to advantage nurses. More fundamentally, the RNABC was an advocate for health promotion strategies and many of its publications reflect a community health interpretative frame (RNABC 1992, 1994a, 1994b, 1996 and 1998). However, there was no nursing coalition supportive of New Directions. The British Columbia Nurses’ Union was hostile to core elements of New Directions, and was threatened by the prospect of institutional sector job losses resulting from health care reform. Throughout the early 1990’s, BCNU was also locked in a battle with the RNABC over the future of nursing, qualifications for practice, and the prospects for an independent community nursing practice role. In short, intra-professional differences in frames of reference, and situational differences in roles and interests, precluded the formation of a nursing-based health policy coalition.

The third finding is that the only coalitions that gelled and acted in a coherent fashion were special interest groups. There were three. The first two were coalitions of advocates for patients – the B.C. Coalition for Health Care Reform and the Association of Advocates for Health Care Reform. Their interest lay in increasing service levels and accessibility. The third was the coalition of anti-abortionists. The first two were included in stakeholder consultations but were ignored by the government. The third was excluded entirely from the policy process.

The fourth finding is that organized labour’s role in the policy implementation process fits poorly with the policy community literature. While there were arguably corporatist elements of policy concertation, the relationship amongst the unions was conflictual (especially between the BCGEU and the HEU over control of community care workers). Further, government’s purpose was not the corporatist one of managing the health care sector through employers and unions, but the more mundane purposes of avoiding essential service strikes and keeping organized labour (a critical NDP electoral constituency) from abandoning the party. Union involvement in the process proved important not because the unions lobbied for specific concessions in the reform policy nor because of corporatist policy concertation, but rather because union involvement protracted the policy implementation process and facilitated the shifting of policy to conventional, less disruptive patterns.

The policy community literature is unhelpful because no meaningful policy community can be found in the B.C. case. Coalitions and interest intermediation between state and societal actors do not describe the dynamics of British Columbia’s health reform process. Pluralist theoretical assumptions prove misleading, because the evolution of policy cannot be accurately described as a product of the positions and tactics of institutional actors engaged in the policy sector. The story is not a story of power plays by union and professional providers in interaction with the state.
Further, the story of B.C. health care reform is not a story about ideational change or policy learning. Rather, the case study shows the government’s interpretative and action frames shifted in a more or less ad hoc fashion, partly due to contradictions and unresolved issues in the original policy formulation, and partly due to the exigencies of implementation. While governmental gradualism and flexibility had the merit of avoiding confrontation with organized interests, the result was attenuation of policy principles to the point where the policy could be reconciled with existing interpretative frames and institutions – in short, reform content was progressively lost. The potential for policy controversy was averted at the cost of confirming the status quo. For that reason, the situation reverted to one that is more or less accurately depicted by a pluralist analysis – a distributive dispute between the state and providers over levels of resources.
The primary case examined the question of structural power from the meso-level perspective of province-wide policy determinants. This chapter, in contrast, is concerned with the micro-level organizational determinants of power. It is especially interested in the question of whether recent changes have constrained professional power. The chapter examines that question first by assessing the significance of clinical guidelines, second by reviewing changes in the organization of hospital work, and third by analyzing the relationship between doctors and managers. Discussion then turns to evidence of changes in resource allocations between hospital and community services. The chapter ends by evaluating the capacity of the new regional health authorities to effect the changes expected of them. The context for the discussions on resource allocations and the capacity of the regional health authority is the Okanagan Similkameen Health Region.

7.1 Health Reform, Regionalization and Professional Power

A discussion of organizational effects on professional power is complicated because professional control is multi-dimensional. Health professionals may lose a degree of dominance over other health care providers and still retain a high degree of professional autonomy. Likewise, health professional organizations may lose a degree of control over the aggregate level of resources available for their members while individual practitioners may retain substantial discretion over how resources are applied in a given case. Tradeoffs are also possible. For example, economic autonomy may be traded-off for clinical autonomy. Meso-level institutional compromises on policies and protocols may be made in order to protect micro-level clinical decision making. Legal protections of some professional acts may be ceded to other professionals in order to strengthen the protection of those remaining. Further, multi-dimensionality contributes to errors of eliding from issues of dominance to ones of autonomy, and of conflating micro-clinical issues with policy and resource allocation ones (Coburn, 1992; Light, 1991).

Harrison and Pollitt (1994) made a useful start at clarifying the issues by distinguishing amongst three views of medical professionalism. The first view is the traditional one held by the profession itself as part of the health professional interpretive frame. In this frame, the patient is neither a customer nor a client because s/he lacks knowledge of her/his health problem and the alternative means of dealing with it.

Consequently, to enter into a relationship with a professional means entrusting ones' interests to that professional. In order to provide conditions in which such trust is not exploited, two professional freedoms are necessary. One is that the professional must be free from outside interference in exercising his or her expert knowledge in the interests of the patient. The other is that the profession as a
body must be largely self-regulating; patients need to be protected from charlatans and incompetent practitioners, but only the profession itself can provide such protection since only it possesses the necessary technical knowledge (Harrison and Pollitt, 1994; p. 2).

The second view of professionalism emerged from sociology and focused on the concept of occupational control. In this view, professionalism is merely rhetoric that serves to defend privileges and prerogatives (Friedson, 1970).

The third view holds that medical professionalism is a component of capitalist ideology, a systematic construal of illness and disability as contingencies stemming from biological and personal factors for which the state and society are by-and-large not responsible. According to this view, it serves the interests of the capitalist state to maintain the illusion of semi-autonomous health care providers, partly because medical professionalism cloaks the real causes of unequal health status (the prevailing social and economic institutions) and partly because the welfare state can distance itself from rationing and shortages by claiming service decisions are made by independent professionals and not by the state (Navarro, 1986; Offe, 1984).

The first and the second views are relevant to both the institutional (meso) level of the organization and the clinical (micro) level of the individual practitioner. They are thus relevant to the primary and embedded case studies. The third view is, however, a macro view addressing broader social determinants. Its relevance is limited to the observation that flows from it: viz. it may be in the interests of governments, health care managers and even other health care providers to maintain the fiction, if not the reality, of health professional autonomy.

Not only medicine, but also other health care providers have convinced governments of the validity of the health professionals' interpretative frame. Over time, they have extracted a host of privileges from the state (Starr, 1982). They also constructed "managerial hierarchies" exclusive to themselves (Harrison and Pollitt, 1994; p. 5). Each legally defined health profession enjoys some professional freedoms, some protection from competition, and some degree of self-governance based on the premise that the public interest is served through the granting of those privileges. Within B.C., the degree of self-governance and organizational autonomy enshrined in provincial legislation varies from the strong case of medicine to the weak case of professions such as occupational therapy.

Occupational control is also evident in B.C.. All of the health professions that attained a degree of professional freedom and self-governance succeeded in establishing entry criteria for the profession and means of determining qualifications associated with the use of reserved titles. They also succeeded in creating subservient vocational counterparts to assume the more unpleasant and uninteresting aspects of their work. Medical practice spawned a score of technical occupations, nursing created practical nurses and nurses' aides, and rehabilitation professionals created semi-skilled assistants. Nurses, pharmacists, physiotherapists and occupational therapists struggled, in competition with
doctors, to carve out unique (and expanded) clinical bases to solidify their aspirations as professions. None, however, command resources to the same extent as doctors and none control the access to and terms and conditions of participation in the profession to anything like the same degree.  

The hallmarks of professional autonomy are (Friedson, 1970; Starr, 1982):

- self-determination of suitability and qualifications for practice;
- freedom to decide the course of action with respect to one's own patient;
- monopoly over an area of practice.

The hallmarks of professional dominance are:

- command over other personnel and resources;
- influence over hospital and medical policy and procedures.

Autonomy and dominance are not independent. Clinical autonomy cannot be meaningfully exercised without some degree of control over the resources needed for diagnosis and treatment. Personnel and resources cannot be commanded without a degree of legitimacy grounded in professional freedoms and privileges.

Flynn (1992; p. 23) argued that professional dominance extends to methods of financing health care, modes of remuneration, modes of provision and the balance between types of care, the criteria and mechanisms for planning and allocating health care resources, and the extent of state and public oversight. The primary case showed that traditional methods of financing, modes of remuneration and modes of medical care provision were, if anything, more entrenched in B.C. ten years after the reform initiative began. Further, the professional monopoly of medicine remained unassailed. While there were

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226 While the nursing profession in B.C. has the rights to approve schools of nursing and set the nursing registration examinations, the scope of nurses' practice is determined by their employers and bounded by provisions of the Medical Practitioners' Act (RSBC 1996). That contrasts with peer control of licensure exercised by the B.C. College of Physicians and Surgeons, and the peer system of granting clinical privileges through hospital medical advisory committees. In B.C., the medical profession alone is administered by physicians on behalf of physicians.

227 Each Canadian physician was estimated in 1988 to generate over $500,000 annually in health care costs (Coburn Rappolt and Bourgeault, 1997; p. 8).

228 Friedson (1986) argued that doctors preserved their "technical autonomy" – the right to use discretion and professional judgement in their work – but lost influence over the use of resources. Flynn (1992) and Mechanic (1994) criticized his position. Technical autonomy cannot be maintained without some control over policy making and how the work is actually done. Neither can be divorced from control over the level of resources available. Flynn and Mechanic, however, failed to distinguish between the aggregate resources available and those resources immediately available to the individual clinician. Meso-level constraints are compatible with (and may even presuppose) a degree of micro-level flexibility regarding the actual application of resources.
legislative changes regarding public oversight of the professions, the changes were modest.

The questions remaining are: (1) to what degree were an individual physician's freedom of practice eroded? (2) what changes occurred with regard to physician command over other personnel and resources? (3) what changes occurred with regard to physician influence over hospital and medical policy and procedures? and (4) what changes occurred regarding the balance between hospital and (non-physician) community care?

The first question is bound up with the issue of clinical guidelines. It will be examined in the context of the question “to what extent have clinical guidelines in B.C. eroded physician autonomy?” The second question is bound up with the relationship between physicians and other health care providers. It will be examined in the context of organizational trends in B.C. hospitals. The third question reduces to a question about the relationship between doctors, managers and health care governing bodies. It will be examined in the context of organizational changes associated with regionalization in B.C.. The fourth question is amenable to Deep Throat’s advice “to follow the money” (Mechanic, 1994; p. 65). The question is based on the inference that resource flows into clinical (as opposed to non-clinical) services are in the interests of doctors, and that evidence of disproportionate financial support is prima facia evidence of medical influence over aggregate resource allocation.229

7.1.1 Autonomy, Clinical Guidelines and Protocols

Everywhere where governments are substantially involved in paying for medical services, pressures have mounted for increased accountability on the part of medical practitioners. The main tool governments have seized upon is the clinical guideline. The state in conjunction with members of the academic medical community seek to commit organized medicine to the development and promulgation of recommended limitations on the use of various procedures and drugs.230 Those guidelines are sometimes regarded as a threat to clinical independence because they constitute “a shift from indeterminate

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229 “Disproportionate” means out of alignment with the actual needs. Unfortunately the expression is inherently problematic because the needs in the community are different from those in the hospital. That is indeed the nub of the problem. If needs are defined (in the way many physicians do) in terms of urgency and the possibility of effecting a short-term change in health status, then almost all the needs are in acute care. From this interpretive frame, community services are desirable but not essential. The perceived imbalance between the acute and community sub-sectors is unfortunate but wholly legitimate. But of course patients quite rightly want not only timely medical interventions but also adequate and effective after care, palliative care services and a host of other responses their real needs. Given the patchwork state of, and limited capacity of, community health care services in B.C., there is a good argument for moving resources into the community, just as the Seaton Royal Commission claimed. Physicians, because of their conventional frame, may agree that there is an imbalance but argue that additional community resources cannot come at the expense of enhancements in acute care. Thus the degree to which resources have been moved out of acute care to meet other needs serves as a useful marker.

230 Of course clinical guidelines may also promote certain procedures. However, where they do so, they are unlikely to be contentious and certainly would not be construed as limiting doctors’ freedom of practice.
expertise-based medical autonomy toward technical evidence-based medical accountability” (Rappolt, 1997; p. 977).

There is no doubt that a tension exists between practitioners and medical elites who promote the adoption of clinical guidelines “in order to avert the imposition of external utilization control” (ibid.). However, the significance of clinical guidelines in the actual practice of medicine, and the extent to which they represent an extension of state power into medicine remain controversial. Additionally, the development of clinical guidelines raises methodological problems. “Medical interventions consist of complex and multiple procedures, and the results of treatment are affected by the patient’s age, the stage of illness, the disease and the presence of complications. Isolating the exact causes of changes in a patient’s condition and measuring the effect of interventions on eventual outcomes is extremely difficult” (Flynn, 1992; p. 98). Methodological problems pale in significance compared to political ones. Obtaining agreement within the profession on guidelines is nearly impossible, resulting typically in one of two outcomes: guidelines are sufficiently generous that no one takes major offense; or a backlash by practitioners results in the guidelines being rescinded or ignored.

In Canada, forays into the field of clinical guidelines have elicited hostile responses from physicians (Rappolt, 1997; p. 981). Some B.C. practitioners, notably specialists, expressed anger that clinical epidemiologists and medical academics challenged their clinical judgement.231

The reaction of physicians in practice stems in part from more conservative members of the medical profession regarding clinical guidelines “as an instrument of the government to control physicians’ practices and incomes” (ibid.). The reaction also stems from the fact that clinicians are more guided by their personal experience (and that of their immediate colleagues) than by academic studies (Mechanic, 1994; p. 7; Lomas et.al. 1989). Most doctors are more impressed by the results they see in their patients than by the reported results of clinical trials. Further, once procedures relying on specific technologies and products are in place, their use is routinized and therefore difficult to change. Moreover, the influence of a single senior clinician may offset the effects of contrary clinical findings, clinical guidelines, and internal institutional protocols.

It is not surprising that local practice patterns are both variable in comparison with one another and internally stable. Even where clinical guidelines have been aggressively pursued and backed by incentives and sanctions, their effects have been difficult to discern. A comprehensive literature review of studies examining the effects of clinical guidelines, clinical management and clinical resource management in the United Kingdom concluded that there is no evidence of increased control over medical practice, no improvement in quality of care provided, and no improvements in consistency and efficiency attributable to clinical guidelines (Flynn, 1992).232

231 The British Columbia Office of Health Technology Assessment has repeatedly attracted this kind of negative attention from conservative elements in the B.C. medical profession.
232 See also Harrison, 1988, Harrison et.al. 1989. A Canadian study drew similar conclusions. See Lomas et.al. (1989).
The B.C. case involves clinical guidelines that are wholly voluntary in application and quite limited in number. The joint medical association-governmental process for their development and implementation paralleled the Ontario government agreement with the Ontario Medical Association. Rappolt (1997) found, in the Ontario case, that the agreement and the guidelines flowing from it were without clinical effect. To date, there is no evidence to suggest that the B.C. situation is any different.233

Mechanic (1991 and 1994) and Friedson (1986 and 1994) argued that, even if clinical guidelines could guide practice, medical dominance would remain unassailed. They held that position because, in their view, the medical profession retains control over the process of guideline development, the content of the guidelines, and the means of promulgation. Light (1997) and Coburn (1992) regarded Mechanic and Friedson to be confused. According to Light, they mixed up meso-level professional prerogatives with micro-level clinical autonomy. The critical thing, in Light’s view, is that clinical autonomy may be encroached upon by clinical guidelines. However, Mechanic and Friedson were actually trying to emphasize a different point, namely the institutional power of organized medicine. The rush to clinical guidelines paradoxically increases the span of control of organized medicine, albeit it may do so at the expense of the autonomy of individual practitioners. Mechanic and Friedson both held that focusing on the micro-level of the practitioner carries with it the risk of all too readily concluding that medical power and influence are diminishing.

The underlying pluralist assumptions about power led Coburn, Rappolt and Bourgeault (1997) to conclude that medical professional power in Canada is diminishing because of state co-option of medical elites.234 Building on Light’s idea of “professions in transition” (Light, 1995), the authors claimed that the medical association’s agreement with the government to develop clinical guidelines strengthened the hand of the state over the profession. But this ignores the fact that the professional association gained the right to determine for its members what constitutes “good practice” – a clear positional advantage over its membership. It also assumes the capacity of the association to promulgate guidelines that will actually guide practice – a dubious proposition. Finally, it assumes the professional association will use the new power devolved upon it in the ways government would prefer – another dubious proposition. Thus it may be, and this is surely an empirical question, that individual doctors lose autonomy because of the grant of authority to the profession to set guidelines. But Mechanic and Friedson’s claim that the professional body has actually gained power is more plausible on its face than the co-option thesis.

233 In Canada, provincial medical associations have had some bad experiences with clinical guidelines. For example, the Ontario Medical Association unwisely backed the Ontario Ministry of Health in limiting the clinical use of non-ionic contrast media. It found itself off-side with its own member radiologists and, worse, with the College of Physicians and Surgeons. Worse yet, the Ontario government reversed its position on non-ionic contrast media, leaving the medical association “holding the bag” (Tuohy, 1999; p. 221). Tuohy recently concluded “clinical guidelines . . . played . . . a modest role in clinical practice in Canada” (ibid.).

234 The same micro perspective informs claims that medicine has been “proletarianized”. “The proletarianization thesis . . . is largely a micro-perspective and, not surprisingly, has been criticized for decontextualizing medicine” (Barnett, Barnett and Kearnes, 1998).
In an important sense, all of this is academic since there is no evidence to suggest that clinical guidelines meaningfully guide practice. The discussion is also out-of-scope with regard to regionalization and the embedded case study. The movement to clinical guidelines actually preceded the other elements of the B.C. health reform agenda, and is not bound up with it. The second domain of professional power, the relationship amongst health care providers and their capacity to command human resources, is much more closely connected with organizational change and therefore regionalization.

7.1.2 Control over Work

One of the biggest changes in health care delivery since the 1960’s was the transfer of aspects of professional work to non-professionally trained personnel (Sneller and Ott, 1996). Hospital managers have, as a rule, responded to financial constraints by transferring work to the lowest paid qualified provider – especially when confronted by rising salaries or labour market shortages. B.C. has been no different in this regard.

In B.C., the 1980’s push to “all RN hospitals” (i.e. hospitals where all nursing care was provided by registered nurses) appeared to run up against the tendency to substitute less expensive, minimally qualified labour. However, the displacement of practical nurses by RN’s took place against a backdrop of a shortage of practical nurses, a very narrow wage gap between practical nurses and RN’s, and a labour surplus of RN’s. Ironically, it entailed a de-professionalization of the registered nurse who assumed many menial duties such as meal tray service, basic bedside care and clean-up duties. The “all-RN hospital” went into rapid decline in the 1990’s as RN’s became scarce and the wage gap between practical nurses, nurses’ aides and RN’s grew.235

In B.C. hospitals, technical and support staff cadres increased when savings could be realized through transferring work to them and shrank when technological change, collective bargaining or labour market conditions offered advantages elsewhere. “De-skilling”236 and “multi-tasking”237 combined with the creation of para-professionals across the nursing, technology and support staff areas of the hospital, albeit at a slower rate in B.C. than in Alberta, Ontario or the United States, due to the stronger health care unions in B.C..238

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235 See Orne, et.al. (1998) on the reversal towards assistive personnel.
236 “De-skilling” generally refers to processes that strip off skills from one occupational cadre and transfer them to another with a view to securing a more favourable staff-wage mix.
237 “Multi-tasking” or “multi-skilling” generally refers to processes that add on (often technical and usually unwanted) duties to existing professional roles. Requiring RN’s to double as technicians is an example.
No such organizational and human resource trends are evident with respect to physicians. Richardson et al. (1998) noted that apparent cases of substitution of medical services by nurses and others may not be real. In fact, such apparent cases reflect trends in service development rather than labour substitution. There is no doubt that B.C. physicians have been successful in preserving their scope of practice and control over assessment of qualifications for entry to practice. Rather than transfers of function, only modest delegations of acts (such as the initiation of intravenous lines to nursing) have occurred, and those in contexts where there are advantages to the medical practitioner. Physicians have been remarkably successful in retaining control over both the content and the context of their work. In fact, it could be argued that their dominance over other health care providers has increased precisely because those other providers, unlike doctors, have been subjected to labour substitution and de-skilling. In this regard, B.C. physicians differ from their U.S. counterparts, many of whom have been drawn into “managed care” in corporate contexts where they, like other personnel, are subjected to similar pressures. B.C. physicians continue to decide unilaterally on admissions, discharges, procedures and medications. They remain largely independent of the hospitals in which they practice, drawing their remuneration from the Medical Services Plan based on the services they perform. In short, the B.C. medicare system, by entrenching professional prerogatives and remuneration mechanisms, has served to protect the traditional privileges of medicine.

Post-1993 regionalization increased the threat to B.C. health care personnel of redundancy, labour substitution and de-skilling because regionalization’s raison d’etre was rationalization of services to improve efficiency. The most obvious, and easy, candidates are support staff areas such as laundry, financial and personnel services and materials and information management. Once a single organization is created, the rationale for multiple dietary, housekeeping, laundry and administrative departments disappears and the employees in those departments become vulnerable to organizational change.

That is what occurred in the case of the Okanagan Similkameen in the three years following regionalization. Financial and administrative services were relocated and centralized in Kelowna, a single management information system based on Kelowna General Hospital’s system was mandated for all services in the region, and material management systems were integrated. As a consequence, savings in the form of support staff reductions were in fact achieved.

Clinically, however, no significant changes occurred as a result of regionalization per se. Hospitals within the region had been pressured by over a decade of financial restraint to maximize labour substitution and savings within the narrow parameters of the prevailing

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239 It might be argued that the diminished role of the general practitioner in the hospital setting is an analogue to the labour market trends affecting other health care providers. However, the diminished status of the gp has more to do with the out-placement of routine medical treatment into the community and the virtual disappearance of serious infectious diseases, especially amongst children. In any event, the changes are intra-professional and not relevant to comparisons between medicine and other health care providers.

collective agreements. By the early 1990’s, the effort to integrate service delivery led senior management to favour programme management models over clinically organized services. Nurses, social workers, physiotherapists and occupational therapists found themselves melded together into programme delivery units such as “mental health” or “geriatrics”. Formal reporting relationships were to care coordinators who may or may not be from the same professional background as a given staff member. In short, professional identities and therefore de facto scopes of practice and pecking orders were under assault prior to regionalism, although (non-staff) physicians, as outside private practitioners, were exempt from institutionally-driven programme management effects.

Kelowna General Hospital was, pre-regionalization, on a trend towards becoming a tertiary care hospital and (led by its medical staff) had already divested some of its general hospital functions to smaller facilities. A collaboration amongst acute care hospitals throughout the Okanagan also pre-dated regionalization. Ironically, regionalization to some degree inhibited the rationalization of clinical services, since Vernon Jubilee, a hospital which had close working relationships with Kelowna General and shared a patient catchment area, ended up in a different region as a result of the post-1993 reforms. While regionalization created the theoretical potential for clinical rationalization that could affect health care professionals including doctors, the potential was not realized by the end date of this study (supra, p. 187)

In sum, trends up until the end of 1999 suggested a decline in the professional power of non-medical personnel and an even more serious marginalization of support and administrative staff in the hospital sector. There was no evidence of diminished medical influence over other providers, or clinical changes stemming from regionalization that might affect the practice of medicine. Practice sites had not been limited as a consequence of regionalization, and human resource trends had not caused a “deprofessionalization” of medicine.

241 This is an area where intra-professional conflict may prove relevant. Regionalization fosters Kelowna General’s drive to tertiary care status, a drive that favours medical specialists but carries with it the prospect of a further decline in the role of the gp within that organization.

242 There was a (voluntary) Joint Medical Advisory Committee for all hospitals in the southern interior of British Columbia. Draft plans to integrate and rationalize clinical services across facilities were drawn up in 1994. See Smallwood, Klippert and Boyd (1995) Okanagan Valley Hospitals’ Role and Services Review.

243 By the end of 1999, a nursing shortage was beginning to loom on the horizon. It will be interesting to see how that shortage will influence the deployment of staff, organizational forms, and delegations of duties.
The relationship amongst doctors, managers and governors lies at the heart of the embedded case study. It is a relationship that may be described, with more than a hint of understatement, as complex. Some writers (e.g. Cribb, 1995) argue that the relationship between doctors and managers incorporates contradictions and is therefore fraught with conflict because of divergent values-bases and beliefs. According to this view, physicians value results in the individual cases in which they are involved, are relatively unconcerned with collateral costs, and subscribe to an ethic that values process issues such as the dignity of the patient, quality of life and effective mobilization of all available resources as much as the actual outcomes achieved. In contrast, managers are concerned with aggregate results, the efficient deployment of resources, and the routinization of the care provided. Other writers (e.g. Klein, 1977) argue that differences in values, cultures and norms are overblown. The real issue is resource allocation, and the only point of contention is how many resources each clinician can deploy for his/her patients.

*The administrator of health services must clearly be concerned to maximize the availability of care to the greatest number; the doctor, equally clearly, is concerned to maximize the availability of care to the individual patient in front of him or her* (Klein, 1977; p. 174).

The phrase “managerial control of doctors” is ambiguous. It could assume a difference in frame of reference between doctors and managers and therefore imply an irreconcilable gap in action frames that can only be overcome through authoritative action by one or the other party. Or, alternatively, the phrase could assume only a difference regarding the distribution of resources, with managers occupying roles that lead them to maximize resources available for an entire service or programme whereas doctors occupy roles that lead them to maximize the resources available to them in individual cases. The latter meaning would imply the prospect of negotiations and compromise.

The potential exists for either circumstance (or both) to arise in a real world situation. A general manager hired from private sector manufacturing, for example, may encounter a genuine ideological divergence from the medical staff. However, it is more likely that managers developed their careers within health care. In the case of the Okanagan Similkameen Health District, the chief executive officer and the chief operating officers all spent their entire careers in health care delivery. The chief operating officers, in fact, were (with one exception) health care professionals. This helps to explain why studies have typically shown “a remarkable homogeneity” of culture, a similarity of

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244 Klein does not deny that there is an interpretative frame difference, to use the language of this study, between management and medicine. Rather, he assumes health care managers generally adopt the frame of reference of doctors. Therefore, it is only their different roles with regard to resource use in the hospital setting that give rise to conflict.

245 A medical informant argued, consistent with this point, that doctors encounter no conflict entering into management roles. It is simply a change in perspective from maximizing good for a given patient to maximizing good for an aggregate of patients.
interpretative and action frame, and a complementarity of goals between managers and practitioners (Harrison, 1988).

The idea of “countervailing management powers” is faulty not only because managers are often the passive agents of doctors and other health care providers, but also in so far as nurses and doctors colonize management “bringing to the task a different set of priorities and values” (Barnett, Barnett and Kearns, 1998, p. 198). Hunter (1994) argued that applying new public management approaches to health care with a view to improving accountability has “unwittingly laid the foundations for a resurgence of professional power” through drawing more health care professionals into managerial roles (Hunter, 1994; p. 8). Harrison and Pollitt (1994) commented that the “powers of management have waxed formidably” but increasingly those powers are in professional hands (p. 133; pp. 136-137). General management gives way to clinically informed management (Harrison and Pollitt, 1994; p.140; Hunter, 1992).

Apart from the extent to which there is a real difference in frame of reference between managers and doctors is the question of strategic advantage. Chief executive officers’ careers depend on their ability to keep the organization within budget and yet grow in innovative ways that bring favourable attention to themselves, their board and the government. Those interests can and do conflict with interests of sub-sets of clinicians within the hospital, although their pursuit equally can, and does, advantage other sub-sets of clinicians. More fundamental from the perspective of professional power is the fact that clinical autonomy is “protective of managers, as well as of politicians” (Harrison and Pollitt, 1994; p. 142). It is not in a manager’s interest, and certainly not in the interest of politicians, to be seen as making choices that limit an individual patient’s treatment. Even in the context of broader policies, managers seek a consensus amongst medical staff, and avoid any policy direction that is clinically controversial. No chief executive officer and no board of governors wants to run the risk of the minister intervening because of bad publicity associated with the application of a hospital policy to a particular case. The realities of health care provision, its risks and uncertainty, and the high probability of negative publicity associated with poor outcomes, contribute to a conservative strategic orientation that supports the continuation of clinical autonomy and implicit rationing.  

246 New public management emphasizes delegation of decision making down to the level where the expertise is, customer service, and empowerment of clients/patients. Those values are more consonant with professionalism than traditional managerialism.

247 It may be thought that as parts of medical care become more routinized, managerial scope will increase and professional scope will shrink. However, managers remain by-and-large unable to regularize and render predictable the delivery of complex health care services (Harrison and Pollitt, 1994; p. 138). Management can gain control over uncertain and risky activities if the group of workers involved in that activity “loses control over the supply of its own labour. [T]hen managers can easily replace those who attempt to resist the management line and go on replacing them until they find a group who will conduct the activity in a way that produces results acceptable to top management” (ibid.). Technological change also serves to routinize what was once risky and uncertain. Both factors have had some influence in medicine, but much less than might be expected. While doctors lost some control over the supply of medical human resources, they maintained control over the application of technology and the technologists. Second, the boundaries of the possible keep expanding. Routinized medical care is off-loaded from the in-patient hospital service and replaced by newer, riskier and less predictable procedures.
Thus it is not surprising that the embedded case study found no irreconcilable structures of beliefs and values differentiating medical practitioners from managers. On the contrary, in the Okanagan Similkameen, both sides had a very lively recognition of the roles and responsibilities of the other, and both sides regarded their working relationships as cordial and constructive, although subject to strain because of limitations on resources. Both managers and physicians saw the critical limitations to be the same (not enough long-term care beds; insufficient funds for priority programmes such as kidney and coronary care).

The embedded case study, then, provides no reasons to believe that regionalization has, or will, bring about a triumph of managerialism over professionalism – although in the Okanagan Similkameen (as in the U.K. and New Zealand) regionalization has resulted in a growth in the number of senior managers. The persistence of clinician autonomy is expected as the history of health care, if it demonstrates anything, demonstrates the enormous capacity of doctors to resist both managerial and professional controls. Further, it is not always in the manager’s interests to extend control into clinical areas; in fact it may be contrary to those interests. Moreover, health care management is far from monolithic. Different factions within management have their own clienteles and interests. Programme line managers are more likely to push for programme expansions than staff executives whose careers turn on balancing the books are. Many key managers are also clinicians. Thus for a variety of reasons there are no a priori grounds to assume governments’ push for more management in health care should lead to less provider influence, lower costs or higher quality services.

Regionalization wrought the greatest change in the relationship between doctors and the governance bodies. In the pre-reform period, both the hospital chief of staff and the president of the medical staff sat on the hospital board of trustees, and the centre of gravity for each hospital’s governance was its medical advisory committee. Physicians had direct, regular unmediated interaction with board members.

The formation of the Okanagan Similkameen Health Region brought in its wake the amalgamation of hospitals and the dissolution of their governing boards and medical advisory committees. While the government finally backed away from its stringent conflict of interests guidelines and permitted one (elected) medical practitioner to sit on the regional board, his role was to bring a medical perspective. He could not feasibly represent a medical staff interest given the diversity of hospitals in the region.

Physicians in the Okanagan Similkameen regarded the changes as substantially reducing their access to health governors. There is no doubt that contact with board members was sharply reduced by the creation of a single “super-board” responsible for a wide range of services over a vast geographic area. Similarly, those regional board members who had previously served on hospital boards indicated how remote they now felt from the medical staffs, even though they made substantial personal efforts to meet with medical staff organizations and individual doctors.
Attempts by the board between 1997 and 1999 at building a regional medical advisory committee structure were not very successful. Physicians were by-and-large antagonistic towards the government’s reform initiative, although much less so towards the regional board which was clearly well-intentioned and motivated to develop arrangements that were satisfactory to the region’s doctors. Doctors, understandably, related to their place of practice – the individual hospital – and had little interest in becoming engaged in region-wide issues, many of them remote from their clinical practices. One initiative aimed at closing the gap and creating more voice for physicians was the 1999/2000 regional health board budget proposal to create a full-time medical director to represent the region’s doctors.

The question begged by the reduction in physician access to health care governors is “how much difference did that reduced access make to the influence physicians exercise over matters of importance to them?” One way of answering this is to ask what policy, resource allocation or organizational changes were made between 1997 and 2000 that adversely affected doctors? Informants in the embedded case study were unable to identify any. One possible reason for this is the fact that the regional structure, by necessity, was a highly devolved one. Most of what was previously the board of trustees’ area of responsibility as well as the previous hospital administrators’ was now delegated to the chief operating officer of each of the region’s acute care centres. Physician access to, and satisfaction with the responsiveness of, those chief operating officers was high. Similarly, the chief executive officer for the region made a point of attending medical advisory committees throughout the region and maintaining close, cordial working relationships with the doctors throughout the Okanagan Similkameen. For those reasons, it is unlikely that medical influence changed in any substantial way.

7.1.4 Follow the Money: Regionalization and Resource Allocations

An examination of budgets of the Okanagan Similkameen Regional Health Board would suggest some changes in resource allocation did occur as a consequence of government funding decisions and the influence of the new board structures. Between 1997/98 (the first year the regional health authorities had budgetary authority) and 1998/99, acute care’s allocation rose from $149,425,027 to $154,767,600 – an increase of 3.58%. Continuing care’s allocation rose from $57,411,422 to $65,000,649 – an impressive increase of 13.22%. However, if the pay equity/levelling-up monies (provincial funding related to provincial collective bargaining) and one-time allocations are netted out, the increase in continuing care drops to $3.3 million or 5.8%. That is still impressive compared with community health services whose allocation (net of one time and pay equity payments) was actually lower in 1998/99 than in 1997/98 ($6,972,526 versus $7,067,7660.248

248 Okanagan Similkameen Health Region – Base and Increases, Finance Committee Agenda package, April 20, 1999.
Given that regionalization was supposed to facilitate a major transfer of resources from acute care to continuing care and community health services, the budgets of the Okanagan Similkameen health region suggest that this major goal was not met in the short term. Actual spending patterns give a glummer picture than the budgets. The acute care service in 1997/98 and 1998/99 ran deficits that were in whole or in part offset by reducing spending in continuing care. Michael Newman, a local health activist, estimated the transfer of resources out of continuing care and into acute care services to have exceeded $7.5 million between 1997 and 1999. While the actual amount may be somewhat less, regional officials confirmed that there were substantial deficits, and that those deficits were covered-off by reduced spending in continuing care.

In short, there is no evidence that budgets and actual spending patterns in any way threatened medical and hospital services. In fact, substantial new resources found their way into the acute care service. By spring 1999, the Regional Health Board was announcing further expansions in acute care – in particular a new and much enlarged critical care unit for Kelowna. Meanwhile, plans for new extended care beds were still bound up with the hope that a private sector company would build and operate them.

7.2 Board Control and Accountability

Control is a necessary condition for accountability. A regional health board collectively and its members individually cannot be held accountable for outcomes over which they have no effective control (Day and Klein, 1987).

The interview component of the embedded case study found that board members in the Okanagan Similkameen believed that their participation on the regional health board had the potential to make a difference in terms of health care services provided to the residents of the region. Their continued involvement would scarcely be sensible if they thought otherwise. However, board members expressed frustration that so little of the potential had yet manifested itself. The actual scope of decision making was so narrow

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249 The acute care deficit in 1998/99 was $1.4 million. This is a startling amount because the doctors’ "RADs" and the nursing strike idled much of the acute care capacity, especially from January 1999 to fiscal year end (March 31, 1999). Salary savings resulting from labour disruptions should have placed the acute service in a surplus situation.

250 Statement made by Michael Newman at the annual budget meeting of the Okanagan Similkameen Health Board, May 19, 1999. According to Newman, “the rationalization that [senior regional officials] have worked out is the fact that a percentage of beds in hospitals are filled by people classed as ‘alternative level of care’ which means they are waiting for placement in an intermediate or extended care facility. These are not ‘our’ patients and ‘our’ budget should not have to pay for them, is the argument. Thus they are justified in transferring funds to cover expenses of the community-side’s patients.” (Newman, 1999). Newman argued this is a money grab, plain and simple. Hospitals manipulate their occupancy to maximize the resources available for their favoured areas of expansion. Thus they hang onto patients who do not need hospital services (and hang onto empty beds) as part of their strategy to maximize their share of spending.

251 See infra, p. 152.
that the board’s impact, especially in the critical areas of clinical services and resource allocation, could scarcely be felt.

Board members reported that their freedom of action was seriously constrained by province-wide collective bargaining, ministry mandated core services and standards, and provincial funding mechanisms. The board did not enjoy control over the wages and benefits of their employees (comprising more than 70% of board expenditures) as it had no active role in collective bargaining. Maintaining core programming at an acceptable service level was generally considered impossible at prevailing levels of provincial government funding. That problem was exacerbated by the funding mechanism. The ministry flowed funds to the board in designated “envelopes” – funds were earmarked. The combined effect of insufficient money for mandated services and designation of the purposes for which available monies could be spent was to leave the board with almost no discretionary room for maneuver.

An example of lack of capacity to make re-allocations was community health services. In spite of the board’s unwavering commitment to community health and disease prevention, and in spite of the lobbying efforts of advocates for community-based services, the staffing level in community health remained frozen at its 1993 level. Another example was the difficulty the board had in finding any funds to support the community health advisory committees (CHACs) – the lynchpins between the board and the public. The board struck CHACs to be its “eyes and ears” in the community; they were also expected to organize and deliver health promotional programming at the community level. However, only a few thousand dollars could be found to provide support to the CHACs. The Central Okanagan Community Health Advisory Committee, for example, tried to serve a population of over 125,000 people with an annual budget of $25,000.252

Another dimension of the lack of capacity was the dependence of the board upon its officials. Findings in this regard were identical to those of Chris Ham who found that board members exert little influence over policy and, in practice, do little more than ratify the proposals made by their executive officers. Board members’ influence “was exercised within a framework over which they had little control and in response to ideas developed principally by officers and professional advisors” (Ham, 1986; p. 51).

Board members in the Okanagan Similkameen praised the quality and the integrity of the senior managers. They expressed a high degree of trust in those officials. However, they also expressed a high degree of dependence on staff for information and how that information should be interpreted.253 A number of board members noted that no mechanisms existed to hold the officials or their staff to account. While the board had debated issues like performance appraisals for senior managers, no policies or procedures had been developed.

252 The annual operating budget from which that $25,000 was drawn approached $300 million.
253 Unlike Day and Klein’s study (1987), the embedded case study found no evidence of manipulation of the board by its officials. In the Okanagan Similkameen, there appeared to be genuine trust and respect on both sides.
Funding mechanisms, core services, and mandated standards meant the board lacked autonomy from the ministry. Dependence on officials for information and absence of an accountability framework meant the board lacked autonomy from its officials. Both served as severe limiting conditions on board control, and hence the board’s capacity to be accountable for outcomes within the health region.

The study examined the board members’ perceptions of accountability, thereby partially replicating the British study conducted by Day and Klein (1987). The study found the board members’ perceptions to be ambiguous, indeed contradictory, perhaps because of the underlying sense of lack of meaningful control. Board members regarded themselves to be accountable to the community or the general public, although some stressed the lack of any clear lines of accountability. Each saw themselves accountable to the board. None saw themselves accountable to the minister or the provincial government, although several commented on the government’s power to suspend the board and the minister’s ultimate accountability to the legislature. Board members recognized that control over the board lay with the government although their own sense of responsibility was clearly to the community. Some commented specifically on that contradiction, and blamed the government’s decision to abandon elections as the source of the problem. Some also complained that government appointment impugned the legitimacy of the board, making it difficult to counter the perception amongst members of the public and the health professions that regionalization was government’s chosen tool for “downloading” responsibility and costs. In this regard, several board members stressed that they were not supporters of the NDP and believed that their appointment reflected merit, not patronage. Unfortunately, in their view, the appointment process created a different public perception.

While the board conducted its meetings in public, the study found that in practice most of the work was done in private through sub-committees. Public attendance at open meetings was sparse. With the exception of the occasional special interest group delegation, board members reported very little interaction with the public. Board members also reported that community health advisory committees found it impossible to act as “eyes and ears” for the board. Attempting to serve as two-way conduits of information proved daunting given the enormous amount of information, the pressure of time on decision making, and the low level of interest amongst the general public regarding the board’s activities. Consequently, CHACs shifted the focus of their activity to health promotional events. CHACs did, however, continue to generate public newsletters and reports to the board.

254 The findings are, in every respect, virtually identical. As in Day and Klein’s study, the case study found remarkable levels of civic commitment and extraordinary willingness to work toward public goals in spite of a clear sense of human and financial resource constraints, governmental obstructionism and public indifference.

255 At the 1999/2000 budget meeting, for example, only three members of the public joined the handful of regional board officials in the public gallery. Findings are consistent with the national study conducted by Lomas, Woods and Veenstra (1997).
In short, apart from the passive communications of news releases and newsletters, described by some board members as “purely public relations”, the board had little regular interaction with the public. That gap was not filled by the media, whose interest was only engaged by exceptional events such as fresh battles in the doctors’ war with government over fees, disruptions in services due to labour disputes, reports of a medical misadventure, or an announcement of new programmes or facilities.

Given the findings of the embedded case study, it is thus difficult to conclude that either accountability to the public or public participation in the delivery of health care services was advanced by regionalization. The physicians boycotted the process, and nursed their grievances over the loss of direct access to hospital boards. The regional medical advisory committee was not a success and medical staff activity remained facility-based. Going into the third year of regionalization, by-laws on multi-facility medical practice privileges were in their tenth draft with no agreement in sight. Organized labour regarded the new board, given their newly won rights of participation on that governing board, to be yet another venue to which they could bring grievances related to staffing levels and administration of the collective agreements. Board members found themselves highly dependent upon the ministry and their own officials, without a constituency in the community, and limited to decision making at the margins.

7.2.1 The Regional Health Board Questionnaire

The thirteen members who served the first two-year term (1997-1999) on the Okanagan Similkameen Regional Health Board were requested to complete a mail-in questionnaire. The response rate was 85% (11 respondents out of 13).

The questionnaire explored board members’ perceptions of progress respecting the eight major goals established by government for regionalization. Those goals were:

1. increased emphasis on health promotion and the determinants of health;
2. increased public participation in, and public responsibility for, health and health care services;
3. improvements in support, appropriate training and working environments for health care employees and volunteers;
4. improvements in accessibility to health care resources;
5. moving health care service delivery closer to home;
6. delegating authority and control to regional boards;
7. improving health service integration, coordination and efficiency;

8. shifting care from institutional to community-based settings.

Amount of Positive Change Reported by Board Members
(percentages represent proportions of responses)

<table>
<thead>
<tr>
<th>Goal</th>
<th>Substantial</th>
<th>Significant</th>
<th>Minor</th>
<th>Negligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health promotion*</td>
<td>9%</td>
<td>55%</td>
<td>36%</td>
<td></td>
</tr>
<tr>
<td>Public participation*</td>
<td>36%</td>
<td>36%</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>Support for employees*</td>
<td>27%</td>
<td>64%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Accessibility</td>
<td>9%</td>
<td>45%</td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td>Closer to home*</td>
<td>18%</td>
<td>82%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Devolution of authority</td>
<td>9%</td>
<td>36%</td>
<td>45%</td>
<td>9%</td>
</tr>
<tr>
<td>Health service integration</td>
<td>18%</td>
<td>55%</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>Shift to community*</td>
<td>27%</td>
<td>73%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>5%</td>
<td>33%</td>
<td>51%</td>
<td>11%</td>
</tr>
</tbody>
</table>

The most striking thing about the responses is the perception of board members that so little progress had been made. Fifty-five out of 88 responses (63%) rated the overall impact of regionalization on policy goals to be minor or negligible. Respondents gave particularly poor marks to accessibility, closer to home and the shift towards community resources – the three legs of the Seaton Commission stool. Responses were almost perfectly split on the question of devolution of authority from government to the board. Half thought government had devolved significant authority; half thought otherwise. The result points to a serious ambiguity -- “authority over what?” – an ambiguity that this study has argued bedeviled the health reform initiative from the outset. Only on the matter of integration of services did respondents reach anything like a consensus on significant progress.

256 Each question marked by an asterisk paralleled the July 10, 1995 B.C. Health Association survey of hospital trustees. Understandably, sitting regional health board directors were a great deal more positive regarding the prospects and achievements of regionalization than were displaced hospital board trustees. The surprise was the “closer to home” question. Seventy-nine percent (79%) of hospital board trustees thought regionalization would have little or no effect on moving services closer to home; four years later, eighty-two percent (82%) of regional health board members agreed. That is particularly ironic given that the entire health care reform was touted as “bringing health closer to home”.

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The open-ended narrative component of the questionnaire provided similar results. One board member commented "there has been excellent integration of support services". Another commented that service integration "is rapidly leading to a system where material management, payroll, health records and transcription, dietary, pharmacy and a controlled dose program will tie together client and administrative activity throughout the region". Another board member remarked "we have had good results with respect to support services".

However, not all board members saw the focus on administration and service integration to be positive. "So far, regionalization has been pre-occupied with evolving structure and has not made an impact on patient care. In fact, [we] have seen [a] negative impact in some geographic areas." Another board member commented in an interview that the Okanagan Similkameen appeared to have been preoccupied with administration, management and support services and consequently missed opportunities for programme innovation, partnerships with social and educational agencies, and clinical service reform.

Board members lent support, in the interviews, to the position taken by one of the members on the questionnaire: "public participation has been minimal, even at meetings/forums held throughout the region last fall. [The] perception exists that health boards are political appointees (hacks)". Another board member wrote in a similar vein, suggesting board legitimacy was a serious problem. "I believe in elections for directors as the easiest way to get public confidence." The biggest issue, however, was the scope of the board's control. Members believed the ministry had tied the board's hands through excessively restrictive funding arrangements and programme standards. A typical comment was "it also appears that the Ministry of Health is not willing to relinquish authority in the areas of budgeting and program delivery".

7.2.2 Embedded Case Interviews

The primary case study made the argument that the logic of the Better Teamwork framework which supplanted New Directions at the end of 1996 threatened to transform regional health board accountability from political accountability regarding the purposes of health programme spending to managerial accountability regarding the efficiency of health care services (Klein, 1993; infra. p. 156). The interview component of the embedded case study found evidence of precisely that effect.

First, as one board member put it, the alleged shift "to a broader wellness approach has been singularly unsuccessful". The combined effect of ministry mandated programmes and services, government controls over regional funding, the constraints of collective agreements, and the pressure of the waiting-list crisis made it impossible for the board to give serious consideration to shifts in programme priorities or spending. The board, in effect, had no room within which to exercise normative policy judgements, because its decision field had been narrowed down to technical trade-offs regarding patient access to
services. “Try to take money out of the hospitals and put it into the community when there are patients in the corridor” was one board member’s way of summing up the conundrum.

Second, since the decision field was reduced to technical trade-offs — service production issues that were often urgent — “frequently by the time issues reach the board level, we [the decision makers] are in a state of panic or decision points have already been passed and the board is asked to bless decisions that have already been made [by managers]”. Given the pressures of time, the amount of information relevant to the decision, and the decision’s technical character, it made sense that “the staff give [the board] recommendations, rarely options”.257

Third, with clinical services overloaded and providers reluctant to participate constructively in the reform process, the focus naturally shifted to areas under direct managerial control — administration, purchasing, personnel, financial services and information systems. Such a focus also supported the interpretive and action frames centred on clinical autonomy, providing some distance between board and managers, on one hand, and the perceived scarcity of health care services, on the other (infra. p. 178). However, the work was clearly the work of administration — there is only a cheerleading role for the board to play in administrative support integration. As one board member put it “we’ve done very good work on the integration of services, but if [the board] got hit by a bus, the health care managers would have done that anyway”.

The embedded case interviews also brought to light a number of cleavages on the board. Most significant were different views regarding:

- rural versus urban constituencies;
- the south Okanagan versus the Central Okanagan;
- the relationship of unionized employees to the board;
- the role of the board and the role of management.

Board members from rural communities were sensitive to the implications of service rationalization for smaller communities. They were concerned that any changes could affect “critical mass” since services were so underdeveloped and poorly supported. They also expressed concerns regarding employment in the smaller centres, and wondered if board representatives from larger centres (and senior management) appreciated how vulnerable people in the rural areas felt.

257 Thus the embedded study provides empirical evidence for Ham and Best’s (1990) conclusion that new public management models of health boards reduce the relevance of public input (democratic accountability) because they erode normative dimensions. Concomitantly, new public management expands managerial scope because of the emphasis on technical production and measurement.
The cleavage between rural and urban was accentuated by the perception in the south Okanagan, where the preponderance of small communities lie, that Kelowna (as the hub of the major population centre of the central Okanagan) gained influence at the expense of the southern towns. In part, the perception reflected long-standing rivalry between the largest southern town – Penticton – and Kelowna. In part, it is attributable to the sense of loss of identity suffered by Penticton Regional Hospital as a consequence of regionalization. Not only was Penticton Regional Hospital amalgamated with the much larger Kelowna General, but its regional status was threatened. No longer the regional hospital of the southern Okanagan, it became a satellite operation of the only “truly regional” hospital, the tertiary care centre in Kelowna. The regional health board responded to the alienation of the south Okanagan by maintaining an administrative presence there. It also continued to hold regular board meetings in Penticton. However, the cleavage remained.

The relationship of the board with its unionized employees was controversial. Some board members believed all staffing and collective agreement issues should be dealt with between management and unions. Others felt it was appropriate for board members to bring staffing and labour relations issues to the board table. This was one area where some board members felt that management and the board chair exercised too much control over information and agenda setting.

Board members were not unified regarding the role of the board or their personal role as board members. Some saw their role as primarily facilitative – encouraging a constructive dialogue across programmes, facilities, and constituencies of interest throughout the region. Others saw the board’s role to be primarily one of ensuring financial accountability – that services were efficient and accounting and information practices were beyond reproach. Some saw their role shading into management, and held that they could only discharge their responsibilities if they could exercise meaningful influence over how resources were used within their home communities. Some wanted to see the board capture more of a normative, policy role from the ministry.

Without exception, board members expressed a strong sense of accountability to each other and to the board collectively. That was clearly a powerful limitation, and was seen by board members to be a limitation, on any advocacy role, whether that was on behalf of personal beliefs or some constituency. All felt bound to solidarity and supporting decisions that would serve the best interests of the whole region – even when that conflicted with their personal vision of health care or the interests of their home community. Understandably, some board members wondered if serving on the board could actually contribute to some of the goals they were personally committed to – accessibility, closer to home, and health promotion. Loyalty to fellow board members, and a strong desire to maintain consensus and good will on the board, joined other constraints in limited board action to fairly safe ground, generally bounded by management’s recommendations.
7.3 Embedded Case Study Findings

The first block of questions to be addressed by the embedded case study was:

*How has the regional model of a chief executive officer assuming managerial control of hospital, public health and community health services under the direction of a government appointed citizen board:*

- affected professional and managerial influence over resource allocations?
- affected the relative position of the "Cinderella" community services vis-a-vis medical care and treatment services?
- affected beliefs concerning the proper ends of public spending on health - i.e. fostered a shift from a traditional health services orientation towards a population health perspective? (infra, p. 2).

The study found no evidence that regionalization in British Columbia affected professional influence over resource allocations. The old patterns of spending reasserted themselves. Managerial influence waxed formidably, but the study found many of those managers were themselves health care professionals. The Cinderella services remained on the hearth next to the ashes. While regional health board members demonstrated a continued commitment to (at least elements of) a community health perspective, their energies were devoted to mainstream, conventional health care services. Public opinion, on the other hand, swung against "community health" as fears over waitlists, the quality of health care services, and the intentions and competence of the government mounted.

The embedded study found that the structural bases of professional power, and in particular the institutions of medicare, were protective of professional privileges. Likewise, the organizational power of bureaucrats and managers subverted the reform. The anticipated outcomes never materialized.

The second major block of questions to be addressed by the embedded case study was:

*To whom, and for what, are the new citizen boards accountable? What control do they exercise? How does their exercise of authority affect managers and other health care providers?* (infra, p. 2).

The study found that the new boards are not accountable to anyone. They lack a constituency and have insufficient capacity to act. They are unable to exercise the key necessary condition for accountability – control. Consequently, managers, ministry bureaucrats and health care providers continue to dominate the health sector decision field.
CHAPTER VIII: Summary and Conclusions

Until and unless we review what medicare is and come to some understanding, we are not able to turn away a single patient and the costs will continue to go up because that is the mandate regardless of how much money it costs.

- a Regional Health Board Director

The case study explored the proposition that the New Democratic government in British Columbia attempted to reform provincial health policy. The study developed the position that a reform, unlike piecemeal and incremental policy change, entails advancing a perspective or frame of reference that not only contains some novel elements, but also incorporates beliefs and values which are irreconcilable with prevailing perspectives. While any non-trivial policy change shifts the distribution of benefits and burdens – and is therefore subject to the politics of interest group formation and power tactics – policy reform engages deeper, structural conflict.

The legitimacy of prevailing institutional arrangements (and hence the positional advantages those arrangements bestow) is bound up with the dominant frame of reference. A policy reform is, ipso facto, an assault on the legitimacy of prevailing institutions, and consequently on the pattern of benefits they bestow.

The study illustrates that there are two distinctive levels of politics relevant to policy implementation. The first level is that of pluralist politics associated with incremental change. In the health sector, pluralist politics takes the familiar form of bickering over fees, salaries, benefits and jobs of health care providers, often under the sanctimonious cover of pursuing the public’s right to an acceptable level of health care. Government for their part tries to find the means to spend as little as possible. This is Wilsford’s world where “the politics of health policy, like other public policies, is about resources awarded to some and withheld from others” (Wilsford, 1995; p. 572). It is also the world of one group countervailing the power of another through superior organization or the acquisition of resources.

The second level is one of institutionalized power. Provincial institutions such as medical care insurance and the tri-partite medical services commission, and legal prerogatives entrenched in health professions’ legislation, have been explored within the case study. Each has been shown to embed arrangements that conflict in principle with, and legitimate activities opposing, elements of the health reform agenda. Likewise, institutional arrangements and provincially bargained collective agreements with organized labour embed power relations and distributions of benefits that are irreconcilable with the arrangements required by New Directions.
The study showed how each major constituency in the health sector – professionals, unions, and government – has a distinctive perspective. Existent policies, and the institutions established to give those policies effect, incorporate amalgams of the state, professional and union perspectives, and therefore demonstrate internal contradictions and hence tensions. For example, private provision of publicly funded medical services creates the tension between the state and providers over funding levels, mix of services, and the role of private financing. Overwhelmingly, though, health policy in Canada has reflected the health professional perspective, and the state, unions and professional providers have all agreed that the primary objective of health policy is assured public access to services. The public has held a similar view: “People are proud of the existing system, and see it as a source of collective values and identity” (National Forum, 1997; p. 7).

The congruence between traditional provincial health policy – public medical and hospital insurance that provided at the time of their launch more or less open-ended funding to hospital and medical services – and the institutional forms of the professionalized and unionized health sector is not, on reflection, surprising. Provincial governments in the 1960’s restricted their health policy role to funding and minor regulatory functions, leaving the actual operation of the health care system in the hands of hospitals, their medical staffs and unions, and private practice physicians. The goals of the publicly funded system were the goals of the medical practitioners — viz. increasing volume and intensity of health care servicing — subject only to the government’s capacity to pay. In essence, the health care sector of the late 1960’s was a private sector analogue, the chief difference being that payment for its services was guaranteed by the state.

“Reforms” in B.C. up until the 1993 *New Directions* policy statement were of the incremental, piecemeal kind. From the early efforts in the 1970’s to control costs onwards, they took the form of the purchaser (government) attempting to get some degree of control over charges and volumes through conventional governing tools of regulation and incentives. Incentives were built into the payment mechanisms through pricing (e.g. higher fees for medical practices in rural areas) and global funding for packages of services (e.g. hospital funding “envelopes”). Regulation took the form joint federal-provincial action on limiting immigration by foreign trained medical practitioners, the (ill-fated) attempt to regulate the place of medical practice through the allocation of billing numbers, and limitations on the rights to strike for essential health care workers. In nature, the tools deployed by the provincial government were no different from the tools developed by U.S. federal and state governments (and by U.S. insurance corporations) to mitigate the expense of paying for privately provided health care services over which the payer has no direct control.
What was different, and proved to be significant in Canada, was the fact that medical and hospital insurance put provincial governments into a position where they dealt directly with issues of doctors’ fees and hospital operating costs. The former necessitated entering into a quasi-corporatist arrangement with the medical association to manage fee negotiations; the latter necessitated governmental intervention to create a province-wide collective bargaining framework. Under the NDP government in B.C., the relationship with organized labour also took on quasi-corporatist characteristics. The case shows those arrangements strengthened the institutional power of professionals and unions, and were protective of professional prerogatives. The failure to address them in the B.C. health reform, indeed the inadvertent strengthening of both, severely limited the capacity of the reform to meet its principal objective – greater accountability of health care providers and professionals to the public.

*New Directions* threatened established arrangements and their embedded patterns of power by promising public, democratic accountability. The message was that the health care system would be turned over to community control so that it could be reshaped to serve public rather than provider purposes. Further, *New Directions* staked out the position that those public purposes had to do with the strength of community institutions, collaborations amongst agencies and different levels of government, locally based partnerships, and equality and social solidarity. In short, the health care reform was definitely not about expanding health care services. In fact, it was only practicable if dependence upon that system, and the current costs of its provision, could be reduced.

It comes as no surprise that organized constituencies in health care opposed core elements of the reform. They opposed the reform not because it would entail a shift of resources from one provider group to another (as any piecemeal policy change would), but because it threatened the foundations of the power held by the health care professions and the health care unions.

The NDP government recognized the existence of the structural interests in health care, but underestimated their durability. It, as a newly elected government, was also unprepared for a major policy controversy over health. Consequently, the government sought a strategy that would keep physicians and labour unions, if not on side, at least distracted until progress could be made on regionalization. The government reasoned that building local constituencies of support for the new power arrangements, and forging the regional institutions needed to give them effect, had to occur prior to devolution, and hence prior to operationalizing the broader health reform agenda.

The pacts made with the BCMA and the labour unions did stop them from acting to abort the reform. However, the study shows the arrangements that emerged from those pacts suffocated the reform shortly after its birth. The deal with the BCMA entrenched fee for service medicine and medical professional autonomy. It effectively removed primary care from the health reform agenda. The goals of integration of medical services with other health-related services and of improving public accountability were hopelessly compromised. The deal with the unions led to loss of employer status by the new regional authorities, ossification of existing staff deployments, and rising labour costs in
the form of job protection and "levelling up". It ensured that any new money flowing into the health system would find its way into increased wages and benefits. Effectively, the two pacts meant that no meaningful areas of responsibility were left for transfer to the new regional authorities.

At the time, the implications of the deals were not widely appreciated – not by government nor by the other parties. The government saw them as "side deals", much like the side-deal with ecclesiastical organizations that exempted them from amalgamation into regional authorities. Government clearly believed, at least up until 1995, that the New Directions policy could still be implemented. Doctors and labour, once regions were established, could be somehow “rolled in”. The doctors and unions also remained alert to the prospect of the reform policy surviving its suffocation. The study shows they continued to worry about the implications of community governance and service integration.

It was only after government dropped the community health councils (the engines of public accountability) and the proposed revenue generating powers of regional authorities (a feature that gave them a degree of independence from the provincial government) that the controversy over New Directions finally did die down. The reason adduced by the study is that nothing major in principle now stood between the government’s regionalization policy and the frame of reference of the health professionals and the unions. The government’s regionalization initiative had reverted to something like the original Seaton Commission plan – in Light’s terms, a conventional “state” interpretative and action frame. The reformist “community health” elements were gone.

As long as regions were essentially administrative bodies exercising managerial accountabilities (in contrast to governing bodies exercising political accountabilities), unions and professions had no objection to them in principle. They had no objections in principle to such administrative bodies because, unlike the governance bodies envisaged by New Directions, they constituted no threat to the continuing control exercised by health care professionals and unions. The attention of the parties could return to competition over scarce resources, seeking positional advantage, and enlarging the size of the health care pie – i.e. the pluralist politics of health policy.

In theory, managers are the keys to holding health care professionals and providers accountable. The Seaton Commission was following in the footsteps of the United Kingdom and a number of other Canadian provinces when it aligned the notion of more management with greater accountability. As the study notes, the view is in keeping with the 1980’s credo of the “new public management”.

The study shows why the notion of managerial control of professionals and providers in health care is misguided. More often than not, managers’ perspectives are more congruent with the providers’ than with the public’s, the state’s or the community health perspectives. Managers’ behaviour was, however, important. The evidence of this study is that managers acted as a conservative force, helping to conserve and restore the institutional forms and norms through the reorganization necessitated by regionalization.
For a variety of reasons, ministry of health and hospital managers preferred regional over community structures and worked to defeat the latter in order to ensure the triumph of the former. Bureaucratic impact, especially at the local level, ensured continuity of the old organizational forms, and projected the related norms, beliefs and values into the new regional context.

Bureaucratic behaviour took the form of re-building traditional arrangements within the shell of the new regional structures. That behaviour is attributable to the commitment officials had to the values, beliefs, goals, policies and processes associated with contemporary management thinking, as well as with existing hospital, medicare and public health institutions. Phrased differently, the evidence of this study does not support the contention that bureaucrats were obstructionist or change-resistant, although there was evidence that some officials resisted being transferred out of Victoria to the regions and others acted to protect the scope of their existing authority. Instead, most managers embraced change and perceived themselves to be part of the reform effort. Their influence in transforming *New Directions* into a policy that was more acceptable to themselves, professionals and providers is best understood as a largely inadvertent process of re-framing health policy along lines consistent with the philosophy of new public management, hence the conventional welfare state frame. In other words, the data uncovered in the study point to the alignment of interests, ideas, goals and prevailing institutional arrangements as decisive for the bureaucrats acting in the policy system, just as it was for doctors, unions and ultimately the government.

The study ties together several observed features of the B.C. health care reform. The period opened with one of B.C.’s frequent conflicts between health care providers and professionals over resources (pre-1990). It entered into a period of transition with the new government and the tabling of the Seaton Commission Report (1991-1993). It then entered a period of policy controversy following the announcement of *New Directions* (1993-1996). Finally it returned to a battle between unionized providers, professionals and the government over resources (1997-2000). Along the way, it went through an organizational change (1991-1993) regarding labour and the professions, an attempt at reform (1993-1996), and a second round of organizational change (1997-1999) in the form of regionalization. From a policy content perspective, Seaton Report thinking (centred on the issue of managing health facility utilization and costs) dominated the period 1991-1993. The period 1993-1996 was dominated by the attempt to develop community governance structures that would assume responsibility for health related public activities. The period 1997-1999 marked a return to putting in place the organizational forms and regulatory apparatus that would ensure more efficient use of acute and long-term care health facilities. Put another way, the cycle ran from concerns with administrative accountability (value for money), to political accountability, then back to administrative accountability.
The cycle can also be described as a period of pluralist politics (formation of quasi-corporatist arrangements within a defined policy community), followed by a policy controversy (wherein there was no useful engagement of the parties since each was attempting to undermine the legitimacy of the other), and ending with another period of pluralist health care politics.

The discussion suggests the following typology:

<table>
<thead>
<tr>
<th>Incremental Health Policy Change</th>
<th>Health Care Reform</th>
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<tr>
<td><strong>Form:</strong></td>
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<td>management</td>
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<td><strong>Problematic:</strong></td>
<td>Transferring dollars from acute to long-term care</td>
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<td><strong>Power:</strong></td>
<td>Pluralist/countervailing</td>
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<td>Managerial</td>
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<td>Negotiations/pressure group</td>
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<td>Confrontational/ideological</td>
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<td></td>
<td>Community participation</td>
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<td></td>
<td>Structuralist/institutional</td>
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The study validates two positions taken by Alford (1972, 1975) and Alford and Friedland (1985). The first is the importance of levels of analysis. The second is the persistence of (a) structural interests; (b) the institutions from which those interests derive their power; and (c) the ideas that legitimate those institutions. It is precisely that persistence which makes reform of highly institutionalized sectors such as health care so intractable, just as Alford claimed over 20 years ago. Importantly, the study shows that those who have concluded that structural interests are no longer relevant in the “denser” policy fields in which governments and members of policy communities now find themselves are mistaken, at least with respect to the B.C. health sector. Their conclusion is driven by either a disregard of organizational bases of power or, alternatively, examining cases where those organizational bases are much more eroded than is the case in British Columbia.

The study also shows that timing and place make a difference. If no alternative policy, no reform policy, is being pursued in a jurisdiction, structural conflicts will remain in the deep background. Only superficial battles over relative position and distribution of benefits will be detected in a case study. The position taken by this study is that it would be wrong to conclude that a story of countervailing powers is the true story based on an apparent policy consensus. Consensus does not necessarily mean the absence of structural power; in fact, it is more likely to be the product of ideological hegemony. It is precisely for this reason that American studies typically find diminished medical power in the context of pluralist health care politics. They do so because in the U.S. there is no alternative to the medical perspective, no credible proponent of a health reform policy. Following the remarkable, if somewhat naïve, attempt the NDP government made to transform power relations in the health sector, B.C. returned to just such an ideological hegemony. Because of the failure of the reform initiative, B.C. is likely to remain in that state for some time.
Health reform advocates and community activists who were engaged in the *New Directions* process were alienated not only from the government but also from the health reform agenda. The evidence would suggest that community based programming such as healthy communities and health promotional programming at the community level were actually in worse shape in 1999 than they were ten years earlier. Funding level and human resources, as the study showed, have actually declined for community health services.

Administrative and managerial gains, however, have been impressive. Regionalization allowed for the standardization of information systems and the rationalization of support services. In the Okanagan Similkameen, a competent and committed board was making responsible decisions, albeit within narrow parameters. Importantly, the regional infrastructure was built between 1996 and 1999 to foster greater system efficiency and improved managerial accountability to the government.

None of that means, however, a change in the power relationships; and therefore, in the terms of this study, it does not constitute a reform. The study could not find any evidence that providers or professionals were more accountable to the public following the period of reform than they were prior to it. There is no evidence that resources have been reallocated to community or to long-term care services. In fact, the resource flow has been in the opposite direction. The community health perspective did not supplant a health professional one. In fact the study shows the public is as committed to the conventional delivery of health care services as ever. Government, for its part, expunged the language of health, community health, community health and new directions from its lexicon.

The Cinderella services of public health, addictions and community mental health services all fared poorly. The promised new resources did not arrive, and the community services actually saw a decline in real growth. The creation of the Ministry for Children and Families, government’s panicked response to a crisis in child welfare, bifurcated health services by factoring off services to children, addictions services and community mental health services. Not only did the creation of MCF fragment health service delivery to children and families, it stigmatized maternal and child public health services by aligning them with child welfare and child protection services.

The answer to the question posed by Alford, and forming part of the title of the study -- “dynamics without change?” – is “yes”. The period of the study, 1991 to 2000, was indeed dynamic. Unfortunately, those dynamics did not yield change, at least not in terms of the anticipated changes in power and accountability. Overall patterns of institutionalized power emerged from the period of reform intact. Aggregate resource flows within health care continued to disproportionately favour acute care services. The problem of insufficient long-term care beds and home care services had gotten worse, not better. Real and important organizational changes had been achieved by regionalization and held promise for administrative efficiencies. However, the nature of the B.C. health care sector, with the exception of strengthened position for the major health care unions, remained pretty much unchanged.
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APPENDIX A: Interview Questions

Interview Questions: Government Key Informants:

1. What are the fundamental elements of the government's current health policy and how do they compare with New Directions? What were the major differences between the 1993 New Directions policy and the Better Teamwork policy implemented after 1996? What in your view accounts for those differences?

2. Did organizations such as the BCMA and health provider unions affect the implementation of health reform policy? If so, which organizations, how? How would you rate the extent of their influence?

3. Which organizations sought access to government officials and politicians? Which ones gained access to what level of government? What were the effects of that access? Whose influence was most felt in the policy implementation process? Why?

4. Which organizations did government approach to facilitate implementation of health reform? How receptive were they? What were the results? Was there a constituency supportive of health reform? If so, could they have been more effectively mobilized? How?

5. What are the policy lessons to be drawn from the B.C. health care reform?
Interview Questions: Non-Governmental Organizations

1. What were the principal objectives of the provincial health care system reform launched in 1993?

2. What were the most serious problems facing the health care system in British Columbia in the early 1990’s?

3. Who do you think should be consulted over health policy implementation?

4. Who had power over health care decision making in 1993? Who should have? Has there been a change since 1993 in terms of who has power or how that power is exercised?

5. What role should the public play in health policy?

6. What is your view on amalgamation of health care services?

7. What is your view on the integration of community and clinical services?

8. Should health care services be entirely publicly funded? Should patients contribute to the cost of their care? Which patients for what sorts of care? What ought the role of the private and public sectors be in health care?

9. What are the respective roles of citizens, patients, health care professionals, health sector employees and managers in providing guidance and direction to the health care system?

10. Does the health care system need stronger controls?

11. Do you see any differences between the 1993 New Directions policy and the Better Teamwork policy implemented after 1996? What are the differences? What accounts for the change?

12. How well does the current approach to regionalization, accountability and control reflect [the respondent’s organization’s] beliefs and priorities for the health care system?

13. In seeking to influence the health reform process, did [the respondent’s organization] regard any other organizations as potential allies? Potential adversaries? Why?

14. Did [the respondent’s organization] collaborate with any others? Which ones? How?
15. What kind of access did [the respondent’s organization] have to government? At what level? To what effect?

16. What role do you believe your organization played in shaping the current policy? Other non-governmental organizations?
Interview Questions: Board Chair, Regional CEO, Chief Operating Officer

1. What, in your opinion, were the principal objectives of health care regionalization?


3. Can you identify any specific changes in hospital services, continuing care and public health stemming from regionalization?

4. Have working relationships between administrators of programmes and governing bodies been affected by regionalization? How?

5. Have working relationships between health care providers, health care professionals and managers been affected by regionalization? How?

6. Have the working relationships between programmes been affected by regionalization? How?

7. Has the amount of influence exercised by the medical profession changed as a result of regionalization?

8. Has the amount of influence exercised by health care unions changed as a result of regionalization?

9. Has the amount of influence exercised by the general public changed as a result of regionalization?

10. Can you identify any organizational changes associated with regionalization that might affect who is included in decision making and how much influence different parties (professionals, unions, managers and the public) have over health care delivery?
Interview Questions: RHB Members

1. Do you have access to the complete and unbiased information you require for objective decision making?

2. Do you have the tools and resources to ensure managers, doctors and the unionized health care employees are held accountable to the Board?

3. To whom do you regard yourself to be accountable – the ministry? the Minister? the government? the public? your own community? the taxpayer?

4. How are you held to account? By whom are you held accountable?

5. What mechanisms exist for public influence over regional health care decisions? How effective are they?

6. How active has the general public been in health care reform? Special interest groups? Provider groups? Unions and health care professionals?

7. Whose influence (health care managers, health care professionals, unions, coalitions and interest groups, the general public) is most felt in the region? Whose influence is least felt? Why?

8. What were the top two or three goals of regionalization? To what extent have they been achieved in the S. Okanagan Similkameen?
Interview Questions: Medical Officer

1. Originally, public health services were to report to CHCs. At the end of 1996, the government adopted a regional service delivery model. Which model made the most sense for public health? Why?

2. In what ways has regionalization affected the delivery of public health services in the Region?

3. Has there been integration of public health services with other services? Are public health services themselves more integrated than previously? Can you point to any organizational or procedural changes that have stemmed from regionalization or service integration? What effects do those changes have?

4. Is there more emphasis on public health, population health and health promotion as a result of the reforms launched in 1993? Are there more resources available for community and public health now than five years ago compared with hospital and medical services? Have the relative importance and levels of resource provision for community and preventive services improved as a result of the health reform?
Interview Questions: Interview of Chair, Community Health Advisory Committee

How effective has the CHAC been in providing a vehicle for public participation in health care decision making?

How much influence has the CHAC exercised over the RHB?

How influential would you rate local health coalitions? Local special interest groups? Physicians? Unionized health care workers? The general public?

Has regionalization effected who exercises how much influence over health care decision making? In which respects?
Appendix B: Regional Health Board Member Questionnaire

Health Care Reform in British Columbia

Regional Health Board Member Questionnaire

You recently concluded a two-year term on the S. Okanagan Similkameen Regional Health Board. For each of the items below, would you please provide your opinion regarding how the present situation compares with the situation when you began your term of office? Please mark the response that best represents your opinion with an “X”.

1. How would you describe the amount of positive change within the Health Region regarding policy and programme emphasis on health promotion and the determinants of health?

☐ “Substantial”: There has been a major positive change since 1996.
☐ “Significant”: There has been significant positive change since 1996.
☐ “Minor”: There has been some positive change since 1996.
☐ “Negligible”: There has been no positive change since 1996.

2. How would you rate the increase of public participation in and public responsibility for health and health care services?

☐ “Substantial”: There has been a major positive change since 1996.
☐ “Significant”: There has been significant positive change since 1996.
☐ “Minor”: There has been some positive change since 1996.
☐ “Negligible”: There has been no positive change since 1996.

3. How would you rate improvements in support, appropriate training and working environments for health care employees and volunteers?

☐ “Substantial”: There has been a major positive change since 1996.
☐ “Significant”: There has been significant positive change since 1996.
☐ “Minor”: There has been some positive change since 1996.
☐ “Negligible”: There has been no positive change since 1996.
4. How would you rate improvements in accessibility to health services within the Region?

☐ “Substantial”: There has been a major positive change since 1996.
☐ “Significant”: There has been significant positive change since 1996.
☐ “Minor”: There has been some positive change since 1996.
☐ “Negligible”: There has been no positive change since 1996.

5. How would you rate the extent to which service delivery has moved closer to the client?

☐ “Substantial”: There has been a major positive change since 1996.
☐ “Significant”: There has been significant positive change since 1996.
☐ “Minor”: There has been some positive change since 1996.
☐ “Negligible”: There has been no positive change since 1996.

6. How would you rate the amount of authority and degree of control that has devolved from the provincial government to the Board?

☐ “Substantial”: There has been a major positive change since 1996.
☐ “Significant”: There has been significant positive change since 1996.
☐ “Minor”: There has been some positive change since 1996.
☐ “Negligible”: There has been no positive change since 1996.

7. How would you rate improvements in health service integration, coordination and efficiency?

☐ “Substantial”: There has been a major positive change since 1996.
☐ “Significant”: There has been significant positive change since 1996.
☐ “Minor”: There has been some positive change since 1996.
☐ “Negligible”: There has been no positive change since 1996.
8. How would you describe the shift from institutional (hospital and extended care) and medical (treatment and diagnostic) services to community-based services?

- "Substantial": There has been a major positive change since 1996.
- "Significant": There has been significant positive change since 1996.
- "Minor": There has been some positive change since 1996.
- "Negligible": There has been no positive change since 1996.

Please provide your comments on the impact of regionalization on health service delivery in the South Okanagan Similkameen Region. In your opinion, why have the various impacts occurred or failed to occur?
## DEPUTY MINISTER'S ADVISORY COMMITTEE ON NEW DIRECTIONS
### as of July 11, 1995

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<th>ORGANIZATION</th>
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### Appendix D

OKANAGAN SIMILKAMEEN HEALTH REGION  
MINISTRY GRANT FUNDING - BASE AND INCREASES  
1998/99 OPERATING YEAR

<table>
<thead>
<tr>
<th></th>
<th>Acute</th>
<th>Cont Care</th>
<th>Mental Health</th>
<th>Public Health</th>
<th>Regional</th>
<th>Total</th>
<th>of total Inc</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Final 97/98 Funding</strong></td>
<td>149,425,027</td>
<td>57,411,442</td>
<td>9,554,743</td>
<td>7,067,766</td>
<td>532,000</td>
<td>223,990,978</td>
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<tr>
<td><strong>Program Specific</strong></td>
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<tr>
<td>Renal</td>
<td>1,309,472</td>
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<td>1,309,472</td>
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<tr>
<td>Tertiary Inflation</td>
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<tr>
<td>Cancer Beds</td>
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<tr>
<td>LTC Beds</td>
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<td>3,150,418</td>
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<tr>
<td>Resident Contributions (1)</td>
<td>(155,052) (304,700)</td>
<td>(459,752) (192,384)</td>
<td>(157,498) (157,498)</td>
<td>(60,000) (60,000)</td>
<td>(194,317) (205,105)</td>
<td>399,422</td>
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</tr>
<tr>
<td>Physician Isolation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>192,384</td>
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<tr>
<td>Mental Health Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>157,498</td>
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<tr>
<td>MRI</td>
<td>60,000</td>
<td></td>
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<td></td>
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<tr>
<td>Ministry Downloading</td>
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<tr>
<td>Transfers (2)</td>
<td>(134,780)</td>
<td>(217,598)</td>
<td>(284,052)</td>
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<td>(636,430)</td>
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<tr>
<td>Other</td>
<td>9,000</td>
<td>80,892</td>
<td>128,962</td>
<td>153,543</td>
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<td>372,397</td>
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<tr>
<td><strong>Total Program Specific</strong></td>
<td>2,473,931</td>
<td>2,737,648</td>
<td>68,862</td>
<td>(130,509)</td>
<td>205,105</td>
<td>5,355,037</td>
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<tr>
<td><strong>Other – Formulas etc</strong></td>
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<td>ECU Funding</td>
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<td>144,486</td>
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<tr>
<td>LTC Care Levels</td>
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<tr>
<td>Pop Demo</td>
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<td>35,269</td>
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<td>122,594</td>
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<tr>
<td><strong>Total Other – Formulas</strong></td>
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<td>604,150</td>
<td>87,325</td>
<td>35,269</td>
<td>0</td>
<td>1,786,555</td>
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<td><strong>Wage Specific – Pay equity, Leveling</strong></td>
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<td>Ongoing</td>
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<td>1,932,247</td>
<td>94,355</td>
<td>191,031</td>
<td>1,895</td>
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<tr>
<td><strong>One Time</strong></td>
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<tr>
<td>Surgeries</td>
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<td>349,083</td>
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<td>685,083</td>
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<tr>
<td>Home Support</td>
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<td>460,000</td>
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<tr>
<td>LTC Beds</td>
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<td>1,250,000</td>
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<td>Salaries, Retroactive</td>
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<td>210,974</td>
<td>31,280</td>
<td>46,914</td>
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<td>312,133</td>
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<tr>
<td>Other</td>
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<td>69,200</td>
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<td>114,305</td>
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<tr>
<td><strong>Total One Time</strong></td>
<td>358,965</td>
<td>2,315,162</td>
<td>31,280</td>
<td>116,114</td>
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<tr>
<td><strong>Final 1998/99 Funding</strong></td>
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<td>65,000,649</td>
<td>9,836,555</td>
<td>7,279,871</td>
<td>739,000</td>
<td>237,623,485</td>
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<tr>
<td><strong>Total Increase</strong></td>
<td>5,342,573</td>
<td>7,589,207</td>
<td>281,822</td>
<td>211,905</td>
<td>207,000</td>
<td>13,632,507</td>
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<tr>
<td><strong>Increase</strong></td>
<td>3.58%</td>
<td>13.22%</td>
<td>2.95%</td>
<td>3.00%</td>
<td>38.91%</td>
<td>6.09%</td>
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</table>

**Notes:**  
(1) Offset by increased contributions from Residents  
(2) Offset by other revenue increases or reduced expenses