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A Fyke in the Road: The ‘New’ Politics of Health Reform

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Less than a year after being appointed, Ken Fyke has submitted his report on the future of Medicare in Saskatchewan. A lot has changed. The premier that appointed him is now gone (and running his own recently appointed national study of the system). The new premier needs to put his stamp on a government he inherited. The coalition government, which has proven more resilient than many expected, is now down a Liberal. The Liberal Party could soon be down a leader. The opposition Saskatchewan Party is increasingly acting as a “government-in-waiting.” A provincial election is one year closer.

In a place where politicians utter the phrase “Saskatchewan, the birthplace of Medicare” as if it were the province’s full name, messing with Medicare is perilous business. One does not tinker with “Saskatchewan’s gift to Canada” just for the sake of it. It is fair to say that Mr. Fyke’s Report goes well beyond tinkering. As such, the “it” comes at a politically delicate time for the provincial government – a time when caution may become the order of the day. Such a situation could result in the province missing an important opportunity to once again demonstrate to the rest of the country that Saskatchewan is still a leader in health policy innovation.

Mr. Fyke has presented Saskatchewan with a clear-eyed and unromantic assessment of the current system’s strengths and shortcomings. The strengths are many, but the weaknesses are every bit as prominent. In short, the fragility of the publicly financed and publicly administered health system in this province (and others) has been, in Fyke’s words, “underestimated”. If we do not move quickly to reinvent the system then the risk of losing it is very real. Fyke’s report is a blueprint for an ambitious reform agenda that seeks, in no small part, to change the very way we talk about, assess and understand publicly funded health care.

The Fyke Report is an attempt to change “the culture” of Medicare to one where “quality of service” and “quality of care” are the central tenets by which we judge the system’s successes and failures. Medicare’s success depends not on the amount spent by governments, but rather the quality of the services received for those dollars. At the same time the report makes it clear that governments can not simply spend their way out of the problems with the system. In other words, to paraphrase James Carville, “it’s the quality, stupid!”

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1 I should acknowledge that I am not a completely disinterested individual when it comes to the work of the Commission on Medicare. I worked (briefly) as a consultant to the Department of Health and played a minor role in the work that led to the Commission. In addition, I provided some advice (in the form of a working paper) to the Commission on the questions of health system governance and accountability. Finally, as part of my own research, I was an observer at the public forums where Saskatchewan residents were asked to consider the contents of Mr. Fyke’s interim report on the challenges facing Medicare in Saskatchewan.
The ambitious nature of Mr. Fyke’s analysis is both the Report’s strength and, quite possibly, its Achilles’ heel. The Report presents an integrated and co-ordinated model of health care for the province. It is centred on primary health service reform in communities across the province, which would be linked to basic acute and emergency care in 14 regional hospitals and specialized services in Regina, Saskatoon and Prince Albert. All of this is facilitated by closing small, under-utilized hospitals; reducing the number of health districts; establishing an arms-length Quality Council to set service delivery standards; implementing a province-wide human resource strategy to retain health professionals; improving health research and information systems; and introducing a collaborative process for confronting the health status of Saskatchewan Aboriginal people. In addition, renewed emphasis on disease prevention, public health measures and health determinants

Governments prefer reports that allow them to pick and choose amongst the recommendations. By weaving the recommendations together and making many of them interdependent, Fyke has made it very difficult (but not completely impossible) for the provincial government to implement only those recommendations that are uncontroversial.

Controversy can be pretty much guaranteed. Rural Saskatchewan is still angry about the last round of hospital closures almost a decade ago. Hospitals are powerful symbols of a community’s existence and important components of the rural economy.

But, according to Fyke, hospitals that can not provide high quality services and care should not be allowed to drain resources from the system when those same resources could provide better quality if deployed differently in the same community.

Concern about hospital closures may reflect less on health care and more on the continuing vitality of small communities. Those concerns are real and have to be addressed honestly and openly. But hospitals should not be seen as instruments of rural economic development. The jobs they create in small communities are indeed important, but their primary function, their raison d’etre, has to remain the provision of quality services to those communities.

The proposals for the reform of primary services, what Fyke calls “everyday services”, are premised on the belief that the creation of co-ordinated and flexible working teams consisting of a wide range of health professionals will deliver better primary health services than a plethora of small hospitals across the province. Those local teams need to be linked clearly into the 14 or so ‘regional hospitals’ that will be the providers of basic acute and emergency care. In Fyke’s view, this more complete integration of ‘everyday’, acute, emergency and specialized services will raise the overall quality of care and service that rural residents could expect. The Report presents an argument that rural residents are currently ill-served and, in the future, they will be better served.

Will rural residents buy in? Only if the government can convince them that it will deliver on the promise—that it will (this time) build the primary care networks in small communities. And that will only happen if the government works very hard to make Fyke’s case in rural communities that quality of service is more important than a building called a hospital. Indeed, it may be the case that employment in health service delivery could increase in rural Saskatchewan under Fyke’s proposal. The problem is that those jobs will not necessarily be concentrated around a building called a hospital and,
therefore, might be less visible to rural residents. In the politics of health reform, perceptions are very important and this will make the government’s job of “selling Fyke” to rural residents more difficult.

Rural residents are not the only ones in need of convincing. The Saskatchewan Medical Association (though not all doctors) will resist some of the recommendations. The call in the Report to have health districts contract with doctors for services and to adopt alternatives to the current fee-for-service payment regime will be a very hard sell. There is nothing new in the idea of putting doctors on salary (though Fyke insists that this is not the only option) or in moving away from single physician private practices into integrated teams of health professionals. But the political reality is that such a move threatens the turf long protected by practitioners (and not just doctors) within the system. Again, there are increasing numbers of doctors, especially younger physicians and female physicians, that open to alternative forms of remuneration and who are willing to trade some of their turf for a better and more sustainable quality of life. The kind of reforms Fyke proposes will require that the government talk over the heads of the SMA and directly to individual physicians in order to build support for these proposals.

For its part the government and the Department of Health may be reluctant to cede authority and legitimacy to a Quality Council as envisioned by the Report. Indeed the history of such arms-length advisory bodies are decidedly mixed. Whatever sense there may be in trying to insulate decisions around service quality and standards from the vagaries of political interference, it may well be a pipe dream on the part of Mr. Fyke. At some point, the Quality Council will issue a statement that is either politically unpalatable to the government or chastises the government or the Department of Health for some aspect of service delivery. The temptation will be to either dismantle the Council or to fold it into the Department in an effort to have more direct control over its pronouncements.

Given the thoroughgoing nature of Mr. Fyke’s recommendation – premised as they are on changing the culture of Medicare – their implementation is going to be difficult, complex and controversial. It will require a government strongly committed to Mr. Fyke’s vision and one willing to move simultaneously on many fronts. At the very least the building of the primary health services networks will have to proceed in tandem with any closure or conversion of facilities. It might have more success (but at a greater financial cost) to build the primary services networks before it begins closing facilities – demonstrating that what is being built gives better service and making those under-utilized facilities effectively obsolete.

But given the state of the coalition government and the uncertainty over when the next election will be held, an argument can be made for not rocking the boat. The Report, however, detects a willingness for Saskatchewan residents to accept some significant degree of change. Indeed they may be expecting it. This leaves the government with a particularly difficult dilemma.

If it moves quickly to implement the Report then an election could be held in the middle of a period of change and turmoil. If the government delays then the election will revolve around the question “will you implement Fyke’s recommendations?” Neither may be terribly attractive. The government’s decision to appoint an all-party committee to study Fyke, to accept submissions from stakeholders and the public and to hold
hearings on the Report appear to demonstrate an understandable, but not necessarily praiseworthy, caution about how to proceed.

If the government decides to move forward with the recommendations then it needs to be honest about what will be lost while emphasizing what will be gained. The task will be to convince the public, especially rural residents, that they stand to gain far more than they lose. The government will have to involve citizens, health districts and community leaders in the complex process of getting from here to there. It will need to build support from the ground up. It will need to lead the process without simply imposing it.

If the government decides that Fyke’s recommendations are too controversial then it should be prepared to present alternative solutions to the problems Fyke identifies. The same holds true for the Opposition. If not Fyke, then what? It comes down to whether the government has the courage of Mr. Fyke’s convictions and whether the opposition (both inside and outside of the Legislature) can do something more than simply say “no”.

The commentaries that follow all take different perspectives on the recommendations of the Fyke Commission and offer important insights into the scope of change that the Report proposes. Economist Michael Rushton raises important concerns about some of the economic analysis that is both present and missing from the Report, suggesting that the Commission’s mandate precluded serious examinations of some policy options that need to be publicly debated. Denise Kouri’s piece concerns itself with the reorganization of the provincial health system as outlined in the Report and the extent to which the proposed Quality Council, the provincial government, the Department of Health and the health districts themselves will all take on significantly different roles within the system. Martha Horsburgh brings her perspective as a nurse and nursing educator to her assessment of the Report. Her generally positive endorsement of Fyke’s recommendations are predicated on the serious involvement of the nursing profession in any implementation of the changes Fyke proposes. Ronald Labonte and Nazeem Muhajarine bring a critical population health perspective to their analysis, arguing that in many instances Fyke does not go far enough in his discussions of how determinants of health can be incorporated into the restructuring of health systems.

In approaching the Fyke Commission’s work from their unique perspectives and viewing the Report through very different lenses the authors to light a wide range of issues that will no doubt have to be confronted by the government, the opposition, the Department of Health, stakeholder groups and the public as they each grapple with the recommendations that Fyke has presented. What is clear is that there is no consensus amongst the authors about either what is right or wrong in the Report, but it is clear that the Report will continue to be a central element in the ongoing political, economic and policy debates on health care reform in the province.
Economics, Incentives, and the Fyke Commission on Medicare

Michael Rushton
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*Doctor, don’t be buffalooled by the unenterprising. No reason why YOU should lack the equipment which impresses patients, makes practice easy, and brings honor and riches. All the high-class supplies which distinguish Leaders of the Profession from the Dubs are within YOUR reach right NOW by the famous New Idea Financial System: “Just a little money down and the rest FREE – out of the increased earnings which New Idea apparatus will bring you!”*

Sinclair Lewis, *Arrowsmith* (1925)

Economists must approach the Report of Kenneth Fyke’s Commission on Medicare, *Caring for Medicare: Sustaining a Quality System* (the Report) with great humility, for health is surely the most challenging field of applied economics. There is no consensus as to what constitutes equity in the provision of health care services. Efficiency in health care, whatever the mix of public or private sector, is a matter of finding the least bad system. Rapid changes in the technology of health, and in the needs of residents, mean that periodic reviews of the organizational structure are necessary. In his *Report*, Fyke suggests that there are substantial inefficiencies in the current system, stemming from institutional arrangements that generate the wrong incentives for health service providers, and from a *culture*, a way of thinking about what the health system is for, that is anachronistic. In this brief review, I want to describe some features of the economics of health that make policymaking so difficult, discuss how Fyke suggests dealing with them, and draw attention to the critical features of his recommendations over which the reforms will succeed or fail.

A problem common to all government provision of services, whether universities, electric power, or physicians’ services, is that the providers of the service will have a much greater understanding of the *true* costs of providing a given quality of service than the Minister of Finance could ever hope to have. When universities request an increase in their budget allocation, or SaskPower requests permission for a rate increase, those organizations know what amounts are really needed for continued operations in a way that no outsider can verify. That’s what makes the budget process, or the rate review process, so difficult. But the centre of government is not completely at a loss. In universities, the technology of delivering classes and conducting research changes slowly, the history of budget allocations gives a reasonable idea as to how dollars are translated into outcomes, and outcomes are somewhat measurable (although opinions differ on how well *Macleans* accomplishes this). In electrical power, comparisons can be drawn with other jurisdictions, world oil and gas prices are easily observed by anyone, changes are seldom enough that public hearings can be arranged to debate proposed rate increases, and output is easily measured.

However, in health care the problem of budgeting in the presence of specialized knowledge by producers is immense. Technology changes very rapidly, the health care needs of individual patients are known only to their physicians, and while there is a
wealth of data available on health service activities, there is disagreement over what constitutes a good outcome (is a decrease in utilization of the system good or bad?).

At the heart of our current system is a funding mechanism for physicians known as fee-for-service: doctors tell patients what treatments they need, and are paid according to the quantity and type of treatment provided. The incentive problems here are obvious, and the Report notes that such an arrangement is bound to sacrifice quality for quantity.

Among the many recommendations in the Report (there is not room to discuss them all here), the key reform is the creation of Primary Health Service Teams (PHSTs), which would integrate the work of physicians with nurses, pharmacists and other healthcare providers in units that could serve the public, especially in rural areas, more effectively. Physicians in these units would be under contract, but would no longer be paid through a fee-for-service system.

In terms of managing the cost of care, the creation of these teams replaces one kind of incentive problem with another. Still, this might be an improvement. Remember in health care we are looking for the best imperfect solution. But we need to examine in more detail exactly what sorts of problems will arise.

PHSTs will receive budget allotments to provide services to their region of the province, and to work with other PHSTs where coordination of services, or the sharing of specialist services, makes sense. The creation of PHSTs will solve what Fyke sees as a great inefficiency in the way we use our health sector human resources, with physicians isolated from the rest of the health system. In this assessment he is surely correct.

But how will PHSTs be funded? There are two innovations. First, the purchase and maintenance of capital equipment and facilities would be coordinated through the Department of Health rather than through the Health Districts, to bring some rationality to the system and reduce the externalities currently in the system where actions by one district impact negatively on another. Second, funding will be based on health outcomes, and improvements in processes:

> The perverse incentives inherent in traditional funding systems have been recognized for decades, yet despite some improvements … the system remains volume-driven. Work done is paid for, regardless of whether it is appropriate, effective, or efficient. Funding follows activity that need not be related to goals or outcomes. Essentially the system pays for activity and is indifferent to result.

> Payments and reward systems should be geared towards quality, illness prevention, health promotion, effectiveness, and efficiency.

> Organizational units that achieve or surpass quality targets should be rewarded; if their initiatives save money it should not all be “taxed back” to the common pool. (Report, p. 53)

The Report lists a sample of possible performance indicators on page 48, although they are vague, and as anyone who has actually worked with performance indicators will attest, the devil is in the details. How, for example, will we measure the “cost per unit of
added health status”, or whether services are “appropriate”, and how exactly will we rank “institutions on the quality of services such as surgery”? This is a revolutionary way to fund public services, even ones where outcomes are much more easily measured (universities in Saskatchewan are funded, to use Fyke’s words, regardless of whether what is done in them is appropriate, effective, or efficient). Furthermore, there is the well-known problem with performance-linked pay. That is, unless the goals we want the system to provide are very clearly spelled out, individuals in the system will devote too much attention to the aspects of performance that are measured and used as proxies for “quality” and too little attention to what is not measured. Delivery of health services will be plagued with these problems under any conceivable set of quality measures.

Incentives in the public sector are “low-powered” – there is typically very little reward for quality or cost innovation by administrators. Economists have devoted much attention over the past few decades to incentives within large organizations, and without going into the deep technicalities of the subject, here is a nutshell version. The head of the sub-organization in the health care system will make an annual budget request. This person will know the true cost function of what they do, and recent developments in costs and local conditions, better than the central budget authority. The central budget authority knows its weakness, and so wants to design a funding system that encourages the head of the sub-organization to tell the truth. The result is the offer of a “schedule” of payments, related to what the sub-organization claims are its costs. It will generally have what appears superficially to be an inefficient rule: organizations that say their costs are low will be funded less than those who claim their costs are high, but the difference in funding levels will be less than the difference in stated costs. Those claiming low costs will receive a slight reward, and those claiming high costs will receive a slight penalty. So we could interpret the Report’s recommendation that cost savings not be “taxed back” as an application of the theory of incentives in organizations.

But there remains a crucial problem, and it explains why we don’t see much cost innovation in government departments. Fyke’s theoretical system of rewarding good behaviour is in practice never implemented because the central agency promise to reward good behaviour is not credible. If it were, we would see cost cutting actions throughout the bureaucracy being rewarded. But what head of a PHST or District Health Board is going to announce efficiency gains that have reduced their funding needs, and believe that the funding will not immediately be reduced by exactly that amount?

Fyke places great faith, too much faith, in the idea that once we remove fee-for-service payments through the PHSTs, and create an “arm’s length” Quality Council, cost increases can be restrained. With the emphasis on PHSTs, he claims that:

The rate of growth and cost pressures will decrease; purchasing and innovation decisions will be more informed; obsolete practices will be quickly eliminated; personnel will be used more effectively; and people will be healthier and have fewer needs. (Report, p. 76)

But while it is true, to give credit where it is due, that Fyke has found a large number of static efficiency gains – ways to better employ our current complement of resources – the dynamic pressures for cost increases will remain. He has not made the case that the incentives will be in the system to pursue cost innovation, and to resist all of the pressures in the system that are currently driving the high rate of increase in costs.
Just about one hundred years ago the (fictional) prairie doctor Martin Arrowsmith could not resist the lure of new technology that his patients in Wheatsylvania did not really need. This pressure, especially now that patients themselves are often very well informed about new technologies, equipment and drugs, is what drives the inflation in health costs above the rate of increase in government revenues.

Fyke rests much of his hope on a Quality Council drawn from the health professions, the universities and health care organizations. But who would act as “independent people rather than representatives of organizations whose particular interests they are expected to advance,” (Report, p. 50)? Even in the unlikely event that such a body could operate in the manner suggested by Fyke, the imprecise visions of quality measures with which they would have to judge the system would mean the Council would be unable to impose the kind of discipline the system requires. Doctors in the system will still claim that improvements in quality can only come at a price, and all of the pressures of the current system remain.

No system is perfect, and it is hard to disagree with Fyke’s suggestions on PHSTs, a greater focus of preventative care, and increased accountability in the system. He is advocating cultural change, and this only comes but very slowly, and with extraordinary leadership. However, the Report was commissioned in part because of increasing cost pressures, and the feeling that health’s 40% share of the provincial government budget was in some sense “too high”. But there is not enough in the Report to contain what drives cost increases. The Quality Council should be the lynchpin, but as it stands its mandate is too vague, and could well end up being quickly captured by the special interests that Fyke is so concerned to restrain.

On a final note, economists have found that the best discipline for a number of public agencies in terms of quality improvement and cost control is the discipline of the market. Government monopolies follow a pattern of low-powered incentives within the organization, lack of concern for clients, and steady cost inflation. Although Fyke recognizes all of these failings in our current system, he believes that they can be corrected by alterations within the context of government monopoly. The Report contains over one hundred pages of things in the current health framework in Saskatchewan that need fixing, and two pages on why the principles of Medicare, especially on public funding and public administration of health care, are just fine. Fyke himself cannot be faulted for not examining the principles in greater depth; his mandate was to make recommendations through a model that “embodies the core values of Medicare”. But in ten or fifteen years, when another study is commissioned on how we can provide better quality health care while containing rapidly escalating costs, will the mandate allow a greater degree of thinking outside of the box?
Health System Governance After Fyke

Denise Kouri
HEAL.Net

The Fyke Commission recommendations have implications for the governance of the provincial health system. This is especially true for the distribution of authority between the provincial government and the districts, but also for the roles of the boards and the public within districts.

The report opens its discussion of governance by making the evident point that there is a great deal of confusion and tension in the system and this is because the domains of authority exercised respectively by the government and the districts have not been clear nor consistent. The Commission therefore recommends the clarification of the relationship of the health districts to the Government of Saskatchewan. It does not make further formal recommendations about this question, other than its recommendations about the number and size of districts. However, there are also redistributions of authority implied by the far-reaching recommendations on the reorganization of services.

On the main question of regionalization itself, the Commission has no explicit recommendation. However, the report as a whole can be taken as generally supportive of regionalization as a policy. Comment is made on the positive role of districts in making change to the health system, and the recommendations on health services are based on a framework of provincial government and districts sharing the workload. The recommendation to enlarge districts is intended, at least in part, explicitly to increase the power of the districts, by increasing their control over their resources and thereby their effectiveness.

Overall, the Commission’s recommendations favor an increased role for the provincial government compared to the past. “As outlined elsewhere in this report, the Commission believes that Saskatchewan Health must be given a stronger mandate to plan and coordinate the delivery of health services, including human resource planning, while working closely with the districts.” (Report, p.56). The Commission recommends — although this is not a formal recommendation — that one of the first next tasks be to “develop a new accountability framework that balances a stronger central planning role for Saskatchewan Health with delegating authority to the district to organize and deliver the services.” (Report, p.57).

The Commission’s recommendation about reorganizing primary and acute care service delivery might arguably carry the most significant changes in authority. Decisions about locations and resources for acute care services would now be the mandate of the provincial government, while decisions about locations and resources of primary care services, including physicians, would now be the mandate of the districts. This reorganization was based on the principle that there should be decentralization of

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2 Although the Commission recommends that the authority relationships between the districts and province be clarified, the language of the Commission itself on this question is not clear. For example, when the Commission uses a phrase like responsibility for planning, it implies authority to decide, yet does not use the word. This type of language only continues the ambiguity.
everyday, frequent services and centralization of specialist and resource-intensive services.

Regionalization is not only about devolution of authority from provincial to district authorities, it is also about centralizing local power to district authorities. The Commission’s recommendation that there be “province-wide planning for acute care and specialized services led by government, including human resource planning, bed management, construction and maintenance of buildings, and purchase and maintenance of equipment” puts the contentious question of the location (and closure) of hospitals back in the domain of provincial responsibility. Districts would continue to be responsible for managing the hospitals, both tertiary care and regional hospitals. The Commission notes in its discussion that “district planning is often unduly influenced by well-meaning pressure from local health providers and citizens.” It is silent on the question of whether the provincial government is influenced by pressure from health providers and citizens, as of course it has been and would continue to be. However, the Commission’s answer to this problem is to recommend a Quality Council, which would make recommendations on the delivery of specialized services to Saskatchewan Health. The establishment of the Quality Council would move decisions about facilities to the domain of technical expertise and diffuse the pressures of advocacy groups. The Commission’s recommendation to strengthen the recently created Health Human Resources Council might also be seen in the same way. It will move the allocation of human resources to a more provincially coordinated basis, one also using consistent and transparent principles.

The other side of the shift in authority for health service delivery is the districts’ increased responsibility for primary services. The Commission recommends that health districts “be responsible for organizing and managing interdisciplinary, team-based primary health services, including contracting with or otherwise paying family physicians, nurses and the other health professionals.” In a separate recommendation, the Commission proposes that districts be authorized and funded to contract with specialists and manage specialist services. The recommended new relationships with physicians increase the authority of the districts with respect to their own resources.

Before leaving the topic of the changed distribution of authority between districts and provincial government, some comments on accountability and funding mechanisms are in order. The Commission’s recommendations overall place a responsibility on both districts and province to show what they call “value for money.” Reports should be less about activities and treatments and more about their overall effects. Funding mechanisms should be designed to reward effectiveness and efficiency rather than the opposite, as is too often the case at present. In principle, these two recommendations about accountability and funding would reorient the governance of the system. However, the mechanisms are vague at present, so not much more can be said.

The Commission’s recommendation to move to “9 to 12” districts from 32 has been one the most contentious. Indeed it is a definite change in governance. The number of district CEOs and board members will shrink to a third of what they are now. Certainly the Commission itself came to its recommendation partly for these reasons. Districts have trouble now recruiting and keeping CEOs. A smaller number of districts would require fewer CEOs in total and they would have more support. Interestingly the Commission does not argue fewer managers would be required overall. In fact, the Commission argues
that the districts are under-managed, and that fewer larger districts would be more able to pool and make better use of the managers they have. The Commission argued in a number of places that larger districts imply more powerful districts — because they have more resources to deploy, both financial and human, and are more stable.

In its discussion about district size, the Commission talked about the minimum size of the population served. Yet an equally compelling factor that seemed to underlie its recommendations was the notion of a critical mass of resources — each district should have a range of facilities along the continuum of care, with at least one regional hospital, districts should have sufficient human resources to create several teams, acute care facilities should have a minimum number of specialists (3 to 5) to offer a specialty. The theme is that a district or institution must be designed as much in relation to the resources it can amass as the catchment area and size of the population served.

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In keeping with its overall direction of increasing the leadership role of the provincial government, the Commission also argued that fewer districts would make Saskatchewan Health’s job of coordinating easier.

However, the new, larger districts retain their boards and their board structure, including the basic 12-member board with two-thirds being elected and one-third appointed. An additional recommendation is that providers within a district would no longer be allowed to sit on the board. The Commission expressed only lukewarm support for the election of board members, however. It was also silent on the implications for the boards of the larger districts. For example, presumably they would still be elected through a ward system. How would the new wards combine with the former ones?

There can be no doubt that going from approximately 360 board members to about 120 means a reduction in the number of players at the board level. However, if the new districts are more powerful and more effective, then the change may not imply a loss of power. Just as the quality of health care can not be determined by the number of services alone, so too, the quality of representation can not be determined only by the number of representatives.

The Commission states that “The people of Saskatchewan have a right and a responsibility to engage in decision making about the delivery of health services, and to comment on the future direction of the health system” (Report, p. 59) and suggests that being able to elect health boards is one of the ways in which they can do that. However, the Commission provides no further recommendations about the specific role of boards or how they should operate as leadership or governing bodies, nor about their public participation mechanisms. No funds are directed to the development of these boards, many of them now to have responsibility over larger resources and territory than in the past. Good governance depends on the ability of communities of people to work together to wield power effectively. In the strategy of health reform, boards were to be one of the ways for ensuring responsiveness and appropriateness of service, as well as responsible and accountable governance. This role will not change with fewer but larger districts. However, the responsibility of board members as governors of the district will become more salient.

The Commission’s recommendations certainly have implications for the form of governance in the province. However, the effectiveness of that governance will depend on how seriously the province and the district authorities take their role as leaders and stewards of the health care system.
The Fyke Report & Nursing in Saskatchewan

Martha E. Horsburgh
University of Saskatchewan

I examined with interest *Caring For Medicare*, the report of the Fyke Commission, and my overall reaction was highly positive. The thrust of the document, if implemented, will be good news for the people of Saskatchewan and for nursing – both the profession and discipline. As the Report itself suggests, many of the recommendations are not new. They have appeared in other venues such as the *National Forum on Health* (1997). I agree with the Commission that implementation of recommended changes will result in a healthier population, an improved health care system, and work environments that will attract and retain nurse professionals and researchers. My remarks focus on the following interrelated issues: nursing roles and education; research; and regulation and governance.

*Caring for Medicare* calls for an evolution of nursing roles that is entirely consistent with the current direction of the nursing profession provincially, nationally, and internationally. However, formidable challenges will need to be overcome if these roles are to be actualized on the scale envisioned.

Academic resources will be required to prepare nurses for increased integration into primary health care service delivery. For over a decade, the World Bank has urged the increased integration of nurses into primary health care services, and empirical research findings support the integration of nurses in primary health care delivery. Increasingly, North American nursing curricula, both undergraduate and graduate, prepare nurses to be active participants in the delivery of primary health care services. Indeed, the curriculum framework of the *Nursing Education Program of Saskatchewan* (NEPS) is primary health care. The NEPS has been preparing nurses for integration into the delivery of primary health care services for the past five years.

While some nurses are well prepared to play an increased role in the delivery of primary health care services, the majority are not. Many Canadian registered nurses received their education in programs, which prepared them well for work in acute care settings but included little, if any, education in health promotion, public health, community-based approaches to health, and primary health care.

An aggressive educational strategy will be required to augment the knowledge and skills of nurses for re-deployment to the primary health care sector. This strategy should include didactic and clinical learning experiences, and a mechanism to assess and recognize prior learning gained through the work place and through self-educational strategies such as workshops, conferences and literature review. Education must be made available throughout the province, and consideration must be given to provision of financial support for nurses to develop skills while maintaining their income.

An important part of this educational strategy will be the preparation of nurses (and other health providers) for collaborative approaches to patient care. In interdisciplinary teams, members are involved in sequential or concurrent independent activities to meet agreed-upon goals. Team coordination and cohesiveness are maximized and individual health care providers fulfill their optimal potential within their respective
professions (Pringle, Levitt, Horsburgh, Wilson, & Whittaker, 2000). There are examples of interdisciplinary primary health care teams in Saskatchewan, but the majority of health care providers presently work in relative isolation from one another, or in a hierarchical fashion. In many work settings, nurses are socialized to hierarchical relationships, particularly in their interaction with physicians.

Preparation of nurses and other Saskatchewan health providers for collaborative practice will require development and implementation of collaborative education in basic educational experiences, and retraining and support of practicing health professionals who are re-deployed to primary health care teams. There are developing models of collaboration in health education in the United Kingdom, Canada and United States (Pringle, et al., 2000). A well-developed model at East Tennessee State University commenced in 1991. Special electives in primary care were developed and the practice component was concentrated in two primary health care centres established in under-served rural communities (Edwards & Smith, 1996). It is important to note that a variety of challenges must be overcome in order to implement collaborative education and that development and coordination have costs attached to them. Leadership and commitment at the highest levels are required to challenge tradition on a daily basis (Edwards & Smith, 1996).

*Caring for Medicare* states that doctors do many things nurses can do, and nurses do many things aides can do. While it is important to use all health providers to their fullest capacity, one caveat that we must not lose sight of is the importance of continuity of care and “knowing the patient” whether the patient is an individual, family, group, or community. Empirical research and theory have clearly demonstrated that the therapeutic relationship between patient and provider is the basis for professional interaction and the achievement of positive patient outcomes. In our eagerness to use all health providers to the fullest, it will be important that we achieve parsimony in our approach to primary health care. People want to know their provider. Nurses and other health providers are most effective when they “know” their patients. It will be important to maximize continuity of care as much as possible, so that patients receive care “in situ” — from a holistic perspective that encompasses characteristics of the individual, their family circumstances, community and culture. This is particularly important for individuals challenged by chronic illness, mental illness, the elderly, and other marginalized groups. Patients, their informal caregivers and communities, are our first partners in health care. Their self-care and care-giving efforts are at the heart of our work. Professional nursing services are legitimized only when self-care and care-giving resources are inadequate to deal with the patient’s health challenge (Orem, 1995). Nursing at its best is supportive and unobtrusive — quietly supporting the self-care and care-giving efforts of individuals, families, and communities. Paradoxically this virtue has likely contributed to undervaluing of nursing. The complex cognitive work of nursing is not readily visible. The observer often sees only the task performed.

The enhancement of community care centres in rural Saskatchewan is long overdue. Centres, which will support overnight stays and day programs for convalescence, respite, and palliative care, will greatly relieve the care-giving burden of family members, friends, and communities, and facilitate the treatment of patients at home. Again, nurses will require orientation and ongoing continuing education to better meet respite and palliative care needs. Thought should be given to integrating
professional nursing linkages into the 24-hour “hot line” approach so that nurses based in community care centres and rural hospitals can access nursing expertise in a timely way.

Nursing is well positioned in Saskatchewan to respond to the Commission’s recommendation that effort to recruit, educate and train Aboriginal peoples into health-related professions be expanded. Based in Saskatoon, The Native Access Program to Nursing (NAPN) currently focuses on recruitment and retention of Aboriginal students in the NEPS. NAPN support services are broad-based and include social support activities, tutoring, assistance with securing financial support (e.g., band funding), and other kinds of assistance (e.g., locating childcare). NAPN counselors actively recruit to nursing programs and promote the nursing profession among Aboriginal youth. Two Aboriginal NAPN counselors support approximately 60 Aboriginal students. This student population, the largest in Canada, offers the ability to develop Canadian capacity in the area of graduate nursing studies. Support of Aboriginal nurses to pursue academic and research careers is imperative for the future.

The roles envisioned for nurses in Caring For Medicare frame a holistic and fulfilling vision for nurses – one that will attract and retain nurses in Saskatchewan and facilitate Aboriginal peoples joining the nursing profession. However, it is a vision that presents a variety of challenges to basic, graduate, and professional/continuing education.

The nursing profession is based upon a combination of nursing science, other health-related science, and extant practices – practices that have been “handed down” across generations of nurses. Nursing science is developing rapidly as evidenced by the growing number of refereed nursing research journals, the increasing number of research studies being reported in top journals representing other health disciplines (e.g., medicine, psychology, epidemiology), and the methodological sophistication of individual studies. However, nursing is still a relative “newcomer” to Canadian university-based academia. Nurse scientists have had difficulty accessing federal research funding that was, until recently, targeted for the basic sciences and medicine. The Fyke Commission’s recommendation of a commitment of at least 1% of the provincial health budget to research and possibly as much as 1.5 to 2%, is welcome news indeed, and I urge implementation as soon as possible. These moneys will greatly enhance the ability of the academic sector to obtain federal funds (federal grants increasingly require the commitment of “matching” funds).

The College of Nursing, with its critical mass of Ph.D.-prepared faculty, has led the advancement of the nursing discipline more than any other jurisdiction or agency in Saskatchewan, and one might anticipate that this will be the case in the future. However, the College has been stunted by years of under-resourcing. It will be challenging indeed to meet today’s expectations for exponential growth in an era of fierce competition for nurse academics.

Academic nurses are an aging workforce, and in extremely short supply across Canada. Alberta universities are aggressively recruiting to fill over 35 nursing faculty positions, and the University of Saskatchewan, the College of Nursing will be seeking to recruit 15 over the next three years. Recruitment of graduate students is equally aggressive, and once these highly talented students leave Saskatchewan to complete their graduate work, not all will return.

Related to its tradition of building successful research partnerships, the College of Nursing is well positioned to link with other disciplines, colleges of nursing in other
provinces and the United States, and less traditional partners, such as the Nursing Division, SIAST, to expand Saskatchewan’s nursing research capacity. However, these endeavors will require human and physical resources (e.g., space) both of which are in short supply. Growth of the scholarly mandate of the College of Nursing will have to be highly strategic and commensurate with its ability to obtain resources. Quality must not be sacrificed for quantity, and a clear focus must be maintained to build world class strength in a few strategic areas.

The nursing academic sector in Western Canada is coming together to support graduate education and research. The College of Nursing is developing its strategic plan in ways that respond to the needs of Saskatchewan AND are complimentary to efforts in Manitoba and Alberta.

The College of Nursing has real strength in the area of rural health. It is developing expertise in Aboriginal health and education, and forensic and correctional health nursing. The College of Nursing has strong methodological expertise in epidemiological approaches to research, and is seeking to develop expertise in participatory and community-based approaches. The latter will be foundational to the development of Aboriginal health research in partnership with Aboriginal communities and groups. Through partnerships with other Canadian Colleges of Nursing, particularly those in the West, the College may also bring high quality programs to Saskatchewan in areas where the College itself does not have a critical mass of expertise.

*Caring For Medicare* speaks to the formation of two structures that will have research mandates — the new Health Human Resources Council (HHRC) and the yet to be developed Quality Council (QC). Given the very finite supply of health care academics in Saskatchewan, it will be vital that research endeavors be closely coordinated, lest the new structures undermine the research strength of the universities. The universities, the QC and the HHRC may find themselves competing for the research talent in the province, to the detriment of the universities. This could become particularly problematic if the QC and HHRC provide research moneys in a manner that is more readily available than traditional competitive processes.

In summary, *Caring for Medicare* frames a vision for the growth and development of the health research sector in Saskatchewan. Strategic use of resources — both human and physical, will be required to achieve growth in today’s competitive environment. The College of Nursing will be particularly challenged, in light of its past disadvantage and current competing expectations around teaching, research and service.

*Caring For Medicare* proposes governance structures and processes that possess implications for nursing. First, it is imperative that the two nursing deans (or their designates) be involved in the HHRC. The deans are eminently qualified to contribute to the work of the HHRC. On a daily basis, they deal with the empirical constraints that influence Saskatchewan nursing programs, and they bring valuable contextual information regarding national academic strategies, challenges, and issues. The QC must have solid links to the nursing research community to conduct research, facilitate knowledge utilization, implement best practices, and develop health policy. Should Saskatoon District Health become an Academic Health Science Centre with service, education, and research mandates, it will require a governance structure that meets national standards — a structure that brings expertise in all three mandates and that mediates conflicts of interest when they arise.
Finally, *Caring for Medicare* stated that the QC will “review and make quality-oriented recommendations on the scope of practice and division of responsibilities among health care occupational groups, in cooperation with the newly created HHRC. It is imperative that nursing academia, professional regulatory bodies, and unions be full partners in all endeavors relating to the mandate of the QC, and that decisions taken in relation to academic and educational credentials meet national standards. Nurses in Saskatchewan will not be marginalized. They will not accept academic and educational credentials that are less than national and North American standards.

Education and educational credentials emancipate nurses and prepare them for full partnerships in health care. This being said, it will be imperative that nursing programs ensure maximum access and flexibility.

References


Caring for Medicare or Caring for Health? Why Health Care Reform is Only a Small Piece of the Puzzle

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SPHERU

The Fyke Commission will probably be debated most for its recommendations to reduce the number of districts and transform more rural hospitals into health centres. This would be a shame. While not going deep enough, the Commission at least wades into the far more important question of what role a health system plays in making people healthy. This is a troubling question for governments, citizens and health care systems alike. Bluntly stated, health care can help sick people get better, but it plays only a small role in creating or improving the well-being of people and communities. Access to education, employment, income, healthy ecosystems, housing, social networks: These are far more important to how healthy people are (or behave) than whether the supply of physicians and nurses meets World Health Organization standards, or whether care is delivered in the home, in hospitals or in Saskatoon or Regina.

The trouble this creates for governments, as the Commission notes, is that we need to improve the way we measure the “opportunity costs” of increased health care spending. There’s evidence that, dollar for dollar, there would be a great impact on the overall health of people in Saskatchewan if that money did not go into high-end hospital or drug therapy, but was spent on such basics as:

- safe and affordable housing;
- improved education;
- better welfare benefits, with supports to employment;
- environmental protection;
- public health measures (water safety, sanitation, immunization).

The Commission’s forecast of continually rising health care costs should ring loud alarm bells for government and citizens alike. Public funding for many of our collective programs and services fundamental to our long-term health, such as education, welfare and housing, is as much “in crisis” as public funding for health care. We need to hold the line on health care costs now, including costs in rural areas. Otherwise we risk losing other public institutions and programs that are no less important as hospitals and healthcare as the glue that binds us into caring, healthy and productive communities. The Commission is spot-on in reaching this same conclusion.

The trouble this conclusion creates for citizens is that, as the Commission’s polling reveals, yes, we want the health care system to do more to prevent disease. But if we’re the ones with an illness, we want access to every bit of new technological and treatment newspapers and television offer up on a daily basis. How else do we reckon that 75% of us want health care providers to make decisions supported by “the best research evidence,” but 50% of us are still prepared to spend more for procedures, drugs and technologies before such evidence is available? (Almost 30% of us would pay more from our own private pockets to cover these additional costs, yet fewer than 10% of us
actually want the private health care system this would eventually create. Our own opinion? Be cautious making too much of public opinion polls.)

The heart of the problem is this: people who get better after being sick or injured notice the difference. People who stay well because of all the other programs and services working invisibly (even unintentionally) to promote health have no difference to notice, and often little awareness of what keeps them healthy. This, combined with a healthy fear of death, a steady diet of ER re-runs, the rural concern that, should the local hospital close, another nail in the local economy’s coffin gets hammered in, contributes to the reluctance to let go of the medical in favour of the social. In our own work in several countries, we’ve noticed that, we, the public, may sometimes want contradictory things, but we’re not stupid. Ask people what they want from their health care system and they’ll tell you: more doctors, more hospitals, more treatment because, by and large, that’s what health care systems have given them in the past. Ask people what makes them, and their community, healthy, and they’ll tell you: a good job, a decent education, a clean and safe environment, proper housing, less poverty, a sense of community. It’s interesting, too, that when health care systems work to support actions on these “population health determinants,” public support rises.

This leads us to consider the role health care systems can play in population health. The Commission’s heart is in the right place, but its recommendations need more detail and assertion.

- The recommendation to transform more rural hospitals into health centres is welcome, provided there is no net decline (indeed, perhaps, a net increase) in employment. Rural communities globally (it’s not just a Saskatchewan problem) rely on public transfers for economic survival. Many of these transfers come in the form of publicly provided health, education and other services. We may need to engage in a good public debate on just how much of our provincial (and national) rural society is worth preserving, and at what environmental and economic costs. But our public programs do not simply promote health by providing medical services or educating students. They also transfer and re-distribute income and help to create cohesive communities, which is a core determinant of health. That rural hospitals are often a source of pride for community members means any transformation in their role requires care in kindling a new pride in what they will become.

- Kindling this pride, and working to develop more cohesive and healthy communities, should be an important function of the proposed primary health service networks. The Commission is long on the idea of such networks but short on the structure they will require. This might allow for healthy experimentation but any implementation of the Commission’s recommendations will require more precise operational guidelines. We’re partial to the community health centre model, which has been well proven in many parts of Canada and internationally. Such centres usually get only a token nod by governments as engines of health care reform. The Report gives the government an opportunity to fulfill the potential promised by the community-clinic model. Whatever plural form these networks take, they will need to expand upon the range of disciplines mentioned in passing in the Report. Where are the health promoters? The health educators? The community developers who will be able to work with citizens
on health determinants?

- Community development (organizing or supporting social action groups) is the most important contribution health care systems can make to improving health determinants. But it also requires funding protection, or “ring-fencing,” as they call it in Australia and the UK. Health care systems will always be under pressure to treat rather than to prevent. The potential costs of treatment will always exceed the available funding. Without ear-marked funding for community development and health promotion efforts (not a lot, perhaps 1% to 3% of the medical treatment budget) the temptation for health districts will be to shift community health personnel and resources into clinical roles. This has happened in the community health centres in Quebec and Ontario. It has happened in community health centres in Australia and in former health districts in Aotearoa/New Zealand (they have since re-centralized what had been one of the most de-centralized systems in the world). It is happening already in some Saskatchewan health districts.

- The same need for protective funding applies to public health services, either separate from community development and health promotion programs or rolled up into a 3% to 6% share of the overall health care pie. In theory, primary care and public health/health promotion services should be linked. In practice, they proceed from different assumptions and models. Primary care focuses on individuals and individual illnesses. Public health and health promotion deal with whole communities and social conditions. They should talk with each other. They should plan together. But they cannot be managed as sub-sets of the same program. Just as an airplane pilot and a truck driver might share similar interests in planning a better global transportation policy, their day to day work is still different enough for each to retain some autonomy.

- Talking together and planning together are the hallmarks of intersectoral work. Such work, the Commission correctly argues, is where health districts will get the biggest bang for their buck—in making health determinants healthier. Much of this work overlaps with that of education, social services, justice, environment, housing, local government and economic development. Saskatchewan is leading the rest of the country in its efforts to make intersectoral work a feature of its provincial level planning (through the Human Services Integration Forum) and at the ground level where people actually receive public services (through numerous Regional Intersectoral Committees and other local joint planning initiatives). But, like community development, health promotion and public health programs, this work requires a small but dedicated pool of resources.

- All of this work must produce evidence that it is leading the province towards desired health goals. The proposal for a Quality Council to oversee such accountability is an interesting one, though the pudding’s proof awaits the tasting. Such a council would have to recognize that community development and health promotion create changes in social, power and organizational relations, as well as in health behaviours, knowledge and health determinants themselves. Accountability in the “social work”
of changing conditions of poverty, inequality, prejudice or environmental degradation requires different norms and goals than ensuring the quality of medical care. Health determinants such as these are not the singular responsibility of health districts, or the provincial health system as a whole. But it is vitally important that districts and the province monitor and regularly report on changes in these determinants. These health determinant indicators are as much a report card on the future well-being of citizens and communities as they are a source of planning information for health districts and Regional Intersectoral Committees.

- One small caveat on such reporting: the Commission recommends ranking health districts on disease rates and other outcomes. This needs careful consideration. Health districts start off with different histories, populations and resource levels. A district could score worst on several outcomes, but could still be doing a fabulous job in its work. If the Commission’s intent is to create a healthy climate of competitive comparisons, then measuring the improvements each district makes over time prove more effective.

- Finally, all of this good evidence requires good research. The Commission’s call for increased government support to health research, generally, and research on population health determinants, specifically, is welcome news. As a new population health research unit, we know that such a commitment is key to our own growth and survival. More importantly, it is also essential to the development of a strong, knowledge-based economy in the province. Without this approach to economic development, our communities will increasingly lack the resources to create healthy social and environmental conditions, much less afford quality health care for when we fall ill.

In sum, the Commission’s recommendations head Medicare reform in the right direction. Their implementation needs some toughening if they are to increase the health care system’s effectiveness in contributing to the important work of making our social and environmental conditions healthier and fairer for all our citizens. There are two issues, however, on which the Commission is disturbingly silent, not necessarily through its own fault but due to the narrowly provincial focus of its mandate.

The first is the impact on health services of the new and expanding regime of free trade and investment agreements. Consider drug costs, which the Commission’s report acknowledges have increased so steeply that eligibility for the provincial drug plan had to be cut back. Why are drug costs so high? Partly due to federal legislation lengthening the time drug companies can hold exclusive patents over their products, introduced as requirements of free trade agreements. The profit margins of drug companies, already high before patent protection was extended, have since grown to almost four times higher than corporate averages, leading Fortune magazine to name the drug industry as “more profitable than any other.” (April 2001 Fortune 500 Report) There is also concern that current federal negotiations over the General Agreement on Trade in Services (or GATS) could open up the Canadian health care (and education and other public service) market to private, largely U.S. competition. Such agreements could radically change the face of health care delivery in this country. We can only hope the federal Romanow
Commission picks up on the importance of this issue, and the Quality Council is in place soon enough to act as a bulwark against privitization.

Related to this is the need for the Quality Council (or whatever structure the province decides upon) to grapple seriously with health-promoting public policy. Reducing inequality, protecting the environment, ensuring a well-educated citizenry: These require bold new initiatives with real resources attached to them. The last decade has seen a steady increase in income inequalities and environmental degradations in most parts of Canada, and the world. In some instances, Saskatchewan has bucked the trend. Poverty levels for single-parent families appear to have dropped over the past year, while they increased in every other province. We may be doing some things right. But Saskatchewan is not a bubble unto itself. It exists in a federal, and a planetary, landscape. One of the biggest issues we face in population health today is how to re-organize our societies, nationally and globally, so that they are more socially just and ecologically sustainable. The key question for Saskatchewan (and Canada) is not only, as the Commission concludes, how to increase our prosperity. It is how to share the rewards of that prosperity more equitably amongst ourselves, and with those residing in the poorer nations of our planet. It’s a huge question involving all of us, as health care workers, researchers, citizens, neighbours. It is not one that Saskatchewan’s reforming health care system can afford to ignore.